



STYLE OF
CASE : IN RE:

[REDACTED]

PERTAIN TO :

[REDACTED]

FROM : Joshua Tree Physical Therapy/ Dr. Kevin Sigroi, M.D. (Medical Records)

DELIVER TO : Christina Ctorides
Goldsmith Ctorides & Rodriguez, LLP.
140 Sylvan Avenue, 3rd Floor
Englewood Cliffs, NJ 07632

CASE NO.:

COURT:

Order No. 102305.001

STATUS

Pending Legals

Please be advised that we are currently attempting to obtain the appropriate legals from the custodian for this facility.

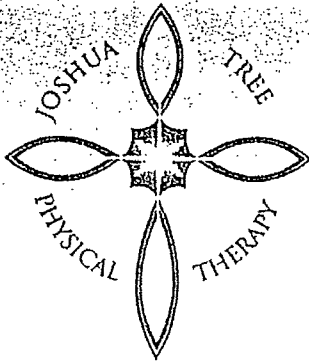
The records turned over by the custodian are available for online viewing.

Do not hesitate to contact our office with any questions or concerns regarding this matter.

Table of Contents

Image Page No.

001-MEDICAL-RECORDS..... 1



JOSHUA TREE PHYSICAL THERAPY

Initial Evaluation

Date: March 17th, 2009.

Physician: Dr. Wescott.

Re: [REDACTED]

Diagnosis: Low back pain/hip pain.

Dear Wescott:

Thank you for referring your patient to Joshua Tree Physical Therapy. Upon initial evaluation the following was determined.

History: Patient is a [REDACTED] female with complaints of cervical spine pain, upper thoracic pain, mid back pain, and low back pain. Patient also complains of frequent headaches throughout the day. Patient's mother was present upon intake of information and verified what her daughter had stated. Patient's headaches and back pain are worse in the morning and does occasionally wake the patient from her sleep at night.

PMH: Patient has been diagnosed with Chiari. Patient has undergone several surgical procedures secondary to this diagnosis. There has been a duraplasty patch surgically implanted at the base of the child's skull. She also has a lumbar shunt to enhance the flow of cerebral spinal fluid. Patient also had surgery for removal of vertebrae C1 and L3 through L5. Patient also has been diagnosed with hypercalcemic production and is taking medication HCTC for this condition.

Objective:

Active Range of Motion

Loss of Movement:

Lumbar flexion:	Moderate with severe complaints of low back pain
Lumbar extension:	Minimal with complaints of low back pain.
Lateral flexion left:	Minimal with complaints of tightness and pulling
Lateral flexion right:	Minimal with complaints of tightness and pulling
Rotation right:	None.
Rotation left:	None

Manual Muscle Test:

	Left	Right.
Quadriceps:	4+/5	4+/5
Hamstrings:	4+/5	4+/5
Ankle plantarflexion:	4+/5	4+/5
Dorsiflexion:	4+/5	4+/5
Dorsi flexion great toe:	4+/5	4+/5

Objective:

AROM.

	Left		Right.
Cervical flexion:		75 % of normal	
Cervical extension:		90 % of normal.	
Lateral flexion:	80 %		80%.
Rotation:	90 %		90%.
Shoulder AROM:	180°		180 °
(flexion)			

8475 NORTH GOVERNMENT WAY, HAYDEN, IDAHO 83815

PHONE: 208-772-9774 FAX: 208-772-9564

Palpation: There are noted numerous trigger points and tonic muscle spasms throughout the cervical, thoracic, and lumbar paraspinals.

Treatment Program: The patient will receive education on proper body mechanics and posture. Treatment and modalities will include, anodyne light treatment, medical massage, neuromuscular reeducation, therapeutic laser, therapeutic exercises, and home exercise program.

Assessment:

Problem List:

- Complaints of pain at rest.
- Complaints of pain with activities of daily living.
- Tonic muscle spasms noted throughout all paraspinals.
- Decreased active range of motion cervical spine and lumbar spine.
- Complaints of constant headaches

Short-Term Goals: Four weeks

- Decrease complaints of pain at rest by 50%.
- Decrease tonic muscle spasms by 50%.
- Increase active range of motion cervical and lumbar spine to WNL.

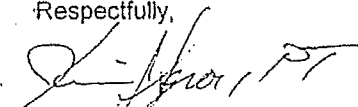
Long-term goals: Eight weeks.

- Decrease complaints of pain at rest to 0/10.
- Patient to perform activity daily living without complaints of pain.
- Decrease tonic muscle spasms by 90%.
- Patient to be independent with supervision in home exercise program.

Plan of Care: The patient will receive the above treatment program two to three times a week for up to eight weeks. The treatment program will be upgraded and modified as per physician's recommendations and as patient tolerates to achieve the above goals.

Once, again thank you for referring your patient to Joshua Tree Physical Therapy. If you have any questions or recommendations about your patient's care please contact me at your earliest convenience.

Respectfully,



Kevin J. Sgroi, RPT

03/18/2009 8:03 AM

Patient Report By Patient Number
LAKESIDE PEDIATRIC & ADOLESCENT MEDICINE

Page 1

Selections:

Registered: 01/01/1990 - 03/18/2009
 Patients: [REDACTED]
 Accounts: 640
 Alerts: Excluded
 Notes: Excluded
 Deactivated: Included

Patient Info:		Default Account: 640		Class:	
806	[REDACTED]	SSN:		Sex:	Female
	2417 E St James	Chart #:		DOB:	[REDACTED]
	Heyden, ID 83835	Registered:	10/09/2007	Race:	C
		First Visit:	10/09/2007	Lang:	ENG
		Last Visit:	02/20/2009	Marital:	Single
	Email:			Assigned:	Westcott, MD, Ronda L.
	Home:	Consent:	Yes	Referring:	
	Work: (208) 762-5519	Referral Src:			
Emergency Contact:					
	Bryant, Caren	Email:			
		Home:	(208) 651-6400		
	Pat Ref to Contact: Grandchild	Work:			
Legal Guardian:					
	Bryant, April	Email:			
		Home:	(208) 762-4201		
	Pat Ref to Guardian: Child	Work:	(208) 772-2400		
		Mobile:	(208) 651-5853		
Accounts:		Acct Finance Grp		Default	Status
<u>Number</u>	<u>Guarantor</u>				<u>Balance</u>
640	Bryant, Wayne	STNID		Y	0.00
Ins. Policies:		Claim Member IDs		Status	Subscriber
<u>Plan</u>	<u>Group</u>				<u>Relation to Sub</u>
1 BC01 - Blue Cross of Idaho	10021000	XBP070191763	Active	Bryant, Wayne	<u>Accept Assign</u>
2 MCD01 - Medicaid		1643066	Active	[REDACTED]	
Extended Info:					
<u>Description</u>	<u>Value</u>				
Dad's Nickname	Wayne Bryant				
Mom's Nickname	April Bryant				

Total Patients: 1

03/18/2009 WED 7:10 FAX 208 292 5441 LAKESIDE PEDIATRICS

00000003



Lakeside
Pediatric

& Adolescent Medicine, PLLC

980 W. Ironwood Dr. Suite 302
Coeur D' Alene, ID 83814

Jean M. Prince, M.D. Ronda L. Westcott, M.D.

Brian J. Hickok, M.D. Jennifer Torok, NP-C

Laine Hughes, FNP

Phone (208)292-5437 Fax (208)416-0170

To: Joshua Tree, P.T.

Attention: _____

Fax number: 772-9564

Date: 3/18

Total Pages Sent: _____

From: Brandi

RE: *Chart notes not completed
yet, I will fax ASAP! *

Thanks.

Confidentiality Note

Unless otherwise indicated or obvious from nature of this transmittal, this information contained in the facsimile message is confidential information intended for the use of the individual or entity named above. If the reader of this message is not the intended recipient or the employee or agent responsible, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error or are not sure whether it is confidential, please immediately notify us by telephone or return the original message to us at the above address via U.S. Postal Service at our expense. Thank you.

Phone (208) 292-5437 Fax (208) 292-5441

Referring Provider: Ronda Westcott, MD

Patient Name: [REDACTED] Age: [REDACTED] D.O.B: [REDACTED]

Parent/Guardian Name: Wayne Bryant

Home Phone #: 208-762-5619

Insurance Policy Holder: Bryant, Wayne

Insurance Carrier: Blue Cross of Idaho / Medicaid

Insurance ID #: XMP970191763 / 1643066 Group #: 10021090

Authorization #: 806 389 000

Referred To: Joshua Tree *Physicist Pharmacy*

Phone Number: 772-9774 Fax Number: 772-9361

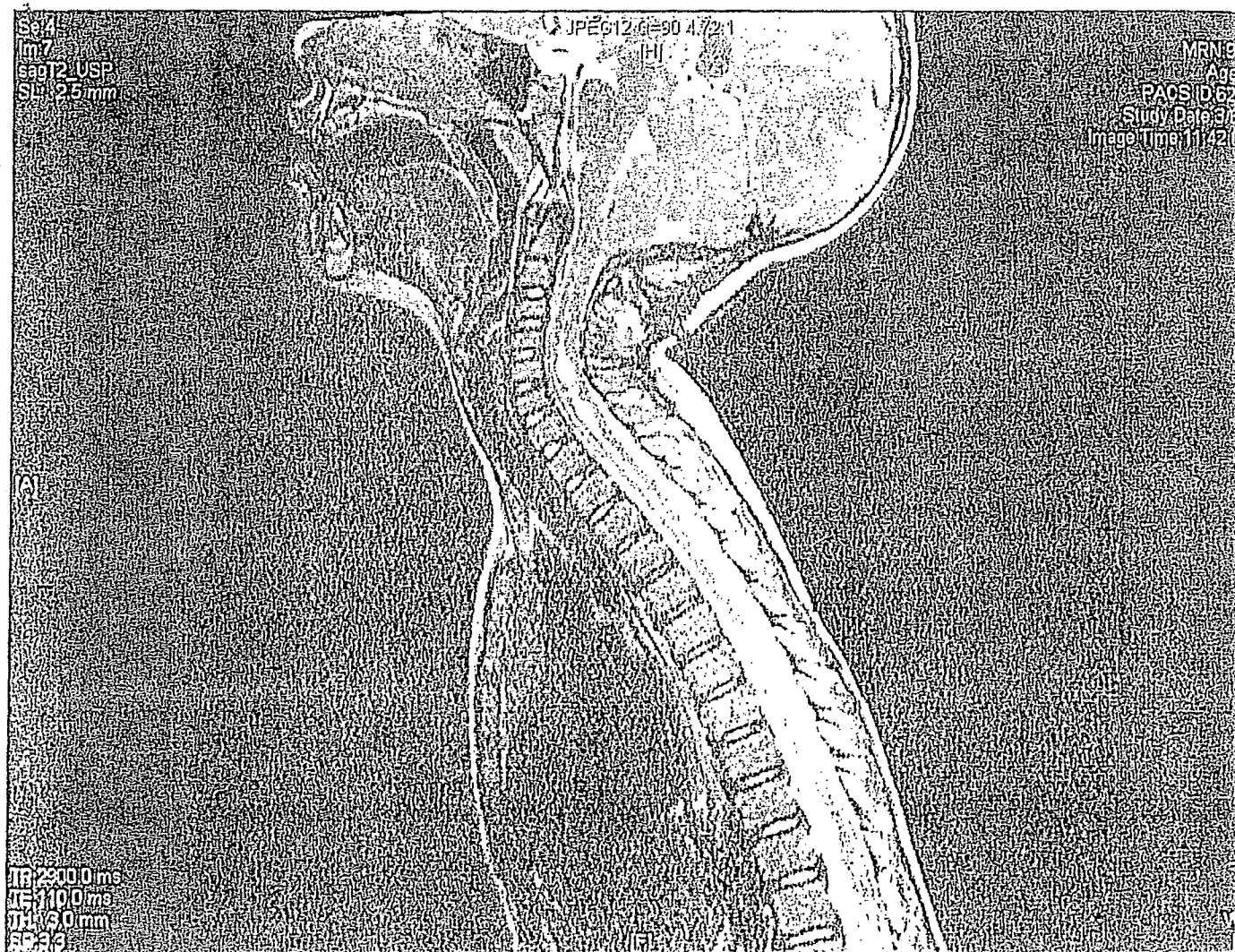
DIAGNOSIS: *Chiari, muscle spasms, headache and decreased ROM*

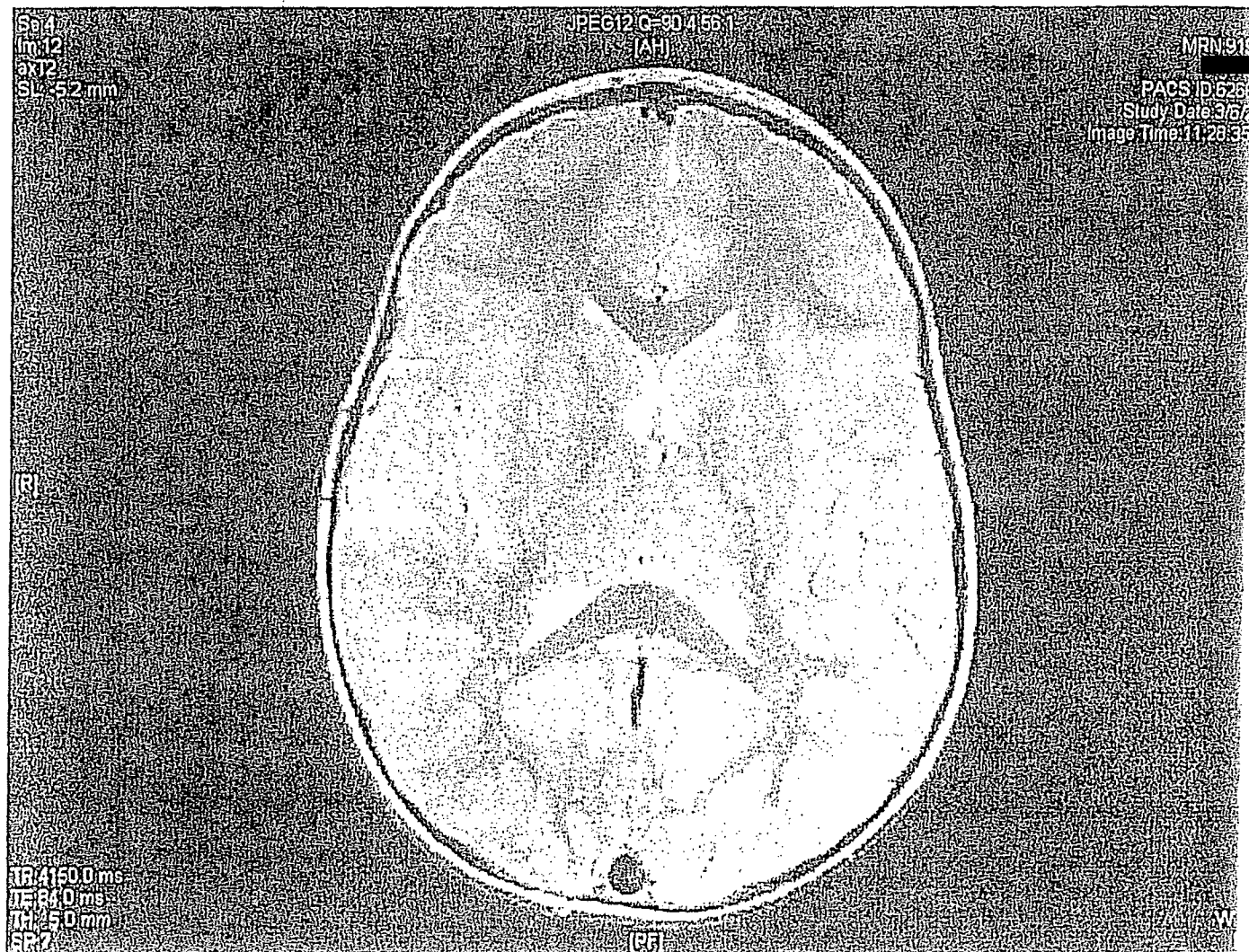
Comments:

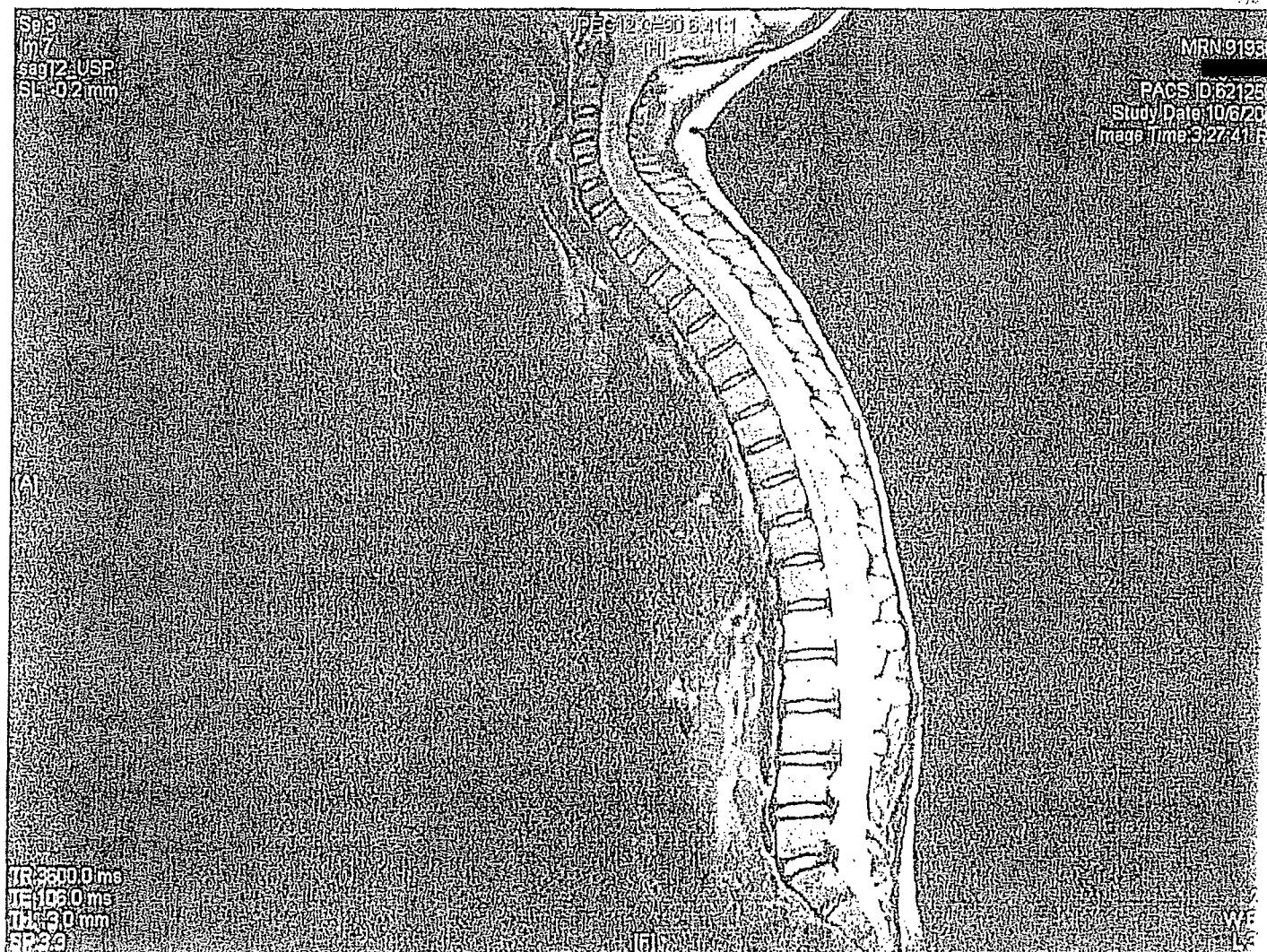
Requested Services: Evaluation, management and physical therapy as needed

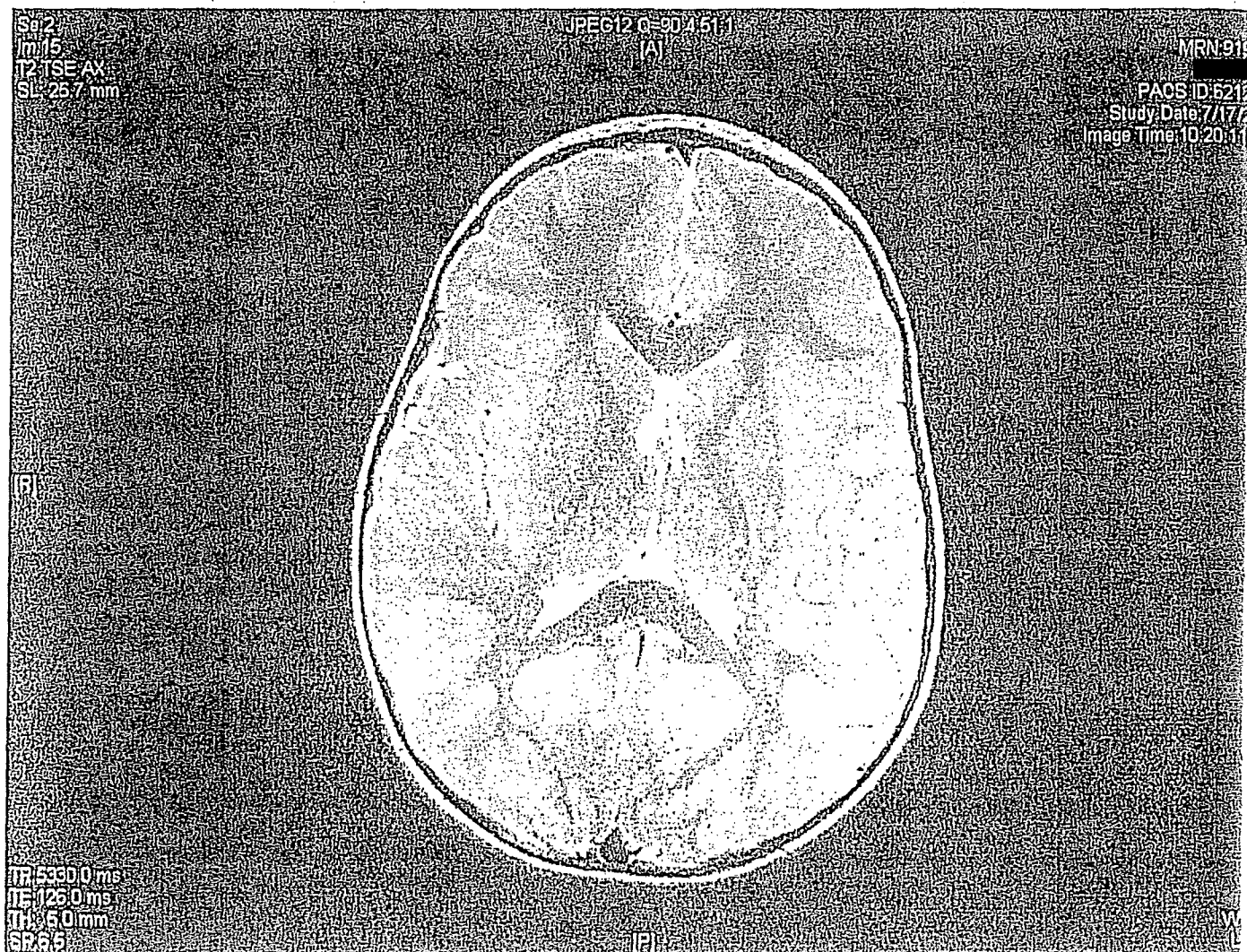
Length of Referral: Effective until March 17, 2010.3

Provider Signature: [Signature] Date: 03/16/09









MR Total Spine w/o Co.

- 919383

* Final Report *

Result type: MR Total Spine w/o Cont
Result date: 06 March 2009 11:55
Result status: Auth (Verified)
Result title: MR Spine Total w/o Cont
Performed by: Hurt, Christopher J, MD on 06 March 2009 13:51
Verified by: Pruthi, Sumit , MD on 08 March 2009 11:04
Encounter info: 90204250, CHMC, Outpatient, 03/06/09 -

* Final Report *

Reason For Exam
syrinx

Results

Clinical History: [REDACTED] d girl status post Chiari I malformation decompression, now with new urinary incontinence and headache

Examination: MRI brain and complete spine without contrast

Comparison: 1 December 2008

Technique:

MR Brain: Sagittal T1, T2; axial T1, T2, FLAIR, diffusion with ADC; and coronal T2. CSF flow studies also performed.

MR Spine: Sagittal and Axial T1 and T2 of the cervical, thoracic, and lumbar spine.

Findings:

Evaluation is somewhat limited secondary to patient motion degradation.

Brain:

Again, patient is status post midline suboccipital craniectomy for Chiari I malformation. There is persistent crowding of the foramen magnum, with low-lying cerebellar tonsils. Previously visualized posterior pseudomeningocele has resolved. CSF flow studies reveal similar degree of severe posterior CSF flow attenuation. Nonetheless, there is decreased anterior CSF flow, which is now moderately attenuated.

Again, there is some tortuosity to the straight sinus, which appears somewhat ectatic.

The ventricles, sulci and cisterns are normal and unchanged. There is no new parenchymal abnormality. There is no diffusion restriction abnormality to indicate acute infarct. Myelination pattern is normal for age. The corpus callosum is normal. Posterior pituitary bright spot is present. There is no extra-axial fluid collection.

Printed by: Carron, Michele , RN
Printed on: 03/09/09 11:28

Page 1 of 3
(Continued)

MR Total Spine w/o Co. [REDACTED]

* Final Report *

The mastoids, paranasal sinuses, and orbits are normal.

Spine:

Again, patient is status post resection of the posterior aspect of the C1 ring for Chiari decompression. There is now absence of portions of the posterior elements at L3-L5, related to introduction of lumboperitoneal intrathecal catheter. Susceptibility artifact in the right posterior abdominal wall upper lumbar region is demonstrated. Intrathecal portion of catheter is noted, exerting anterior mass-effect on the cord at T10-T11.

The alignment is normal. The marrow signal is normal. Based on counting from above, there are a normal number of vertebral bodies.

No disc pathology.

The conus ends at L1. No lipoma of the filum terminale. The thecal sac ends at S1-2.

There is increased extent and prominence of punctate linear and beaded dilatation of the central canal indicating worsening syrinx throughout the entire spine. Maximum anteroposterior dimension of the syrinx now measures up to 5 mm (previously 3 mm).

Moderate amount of free fluid is noted within the pelvis, likely from lumboperitoneal shunt.

Impression:

Increased extent and prominence of syrinx throughout the entire spine, as described above.

Apparent decrease in anterior CSF flow at the foramen magnum. While a portion of this change in flow may be related to alterations in head position, which is more extended on the present study compared with the prior, there may be true worsening in CSF flow at the foramen magnum.

Resolution of pseudomeningocele.

Status post lumboperitoneal shunt placement. Extent of mass-effect on the anterior aspect of the cord at T10-T11 apparently related to the intrathecal portion of the catheter may be greater than expected. Please correlate clinically.

Otherwise stable examination compared with 1 December 2008 in patient status post decompression for Chiari I malformation.

Signature Line

Resident: Hurt, Christopher J, MD

I have personally reviewed this study
and agree with the report above.

Printed by: Carron, Michele, RN
Printed on: 03/09/09 11:28

Page 2 of 3
(Continued)

MR Total Spine w/o Cor.

[REDACTED] - 919383

* Final Report *

S,P/CJH

Radiologist: Pruthi, Sumit , MD

Completed Action List:

- * Order by Pearce, Katherine J, ARNP on 10 October 2008 16:15
- * Perform by Bryant, Charles , RT on 06 March 2009 11:55
- * Assist by Pruthi, Sumit , MD on 06 March 2009 11:55
- * VERIFY by Pruthi, Sumit , MD on 08 March 2009 11:04 08 March 2009 11:04

Printed by: Carron, Michele , RN
Printed on: 03/09/09 11:28

Page 3 of 3
(End of Report)

JOSHUA TREE PHYSICAL THERAPY

REGISTRATION FORM

This information is necessary so that we may serve your needs
Any/all information will not be released without your written consent

Today's date: 3/16/09

Referred By:

PATIENT INFORMATION

Patient's last name: [REDACTED]

First: [REDACTED]

☐ Mr.☒ Miss

Marital status (circle one)

☐ Mrs.☐ Ms.

Single / Mar / Div / Sep / Wid

Is this your legal name?

If not, what is your legal name?

(Former name):

Birth date:

Age: [REDACTED]

Sex: F

☒ Yes ☐ No

Street address: 2417 E. St James

Social Security no.:

Home phone no.:

(202) 762-5619

ZIP Code:

83835

P.O. box:

City: Hayden

State: ID

Occupation:

Employer:

Employer phone no.:

()

Referring Physician: Dr. Westcott

Referring Physician Phone #: (202) 292-5437

Primary Physician: same

Primary Physician Phone #: ()

Date of Injury:

Type of Injury: Work Related ☐ MVA ☐ Other ☐ Unknown []

How did your injury/ symptoms occur?

Congenital

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:

Birth date:

Address (if different):

Home phone no.:

April Bryant

7/28/80

()

Is this person a patient here?

☐ Yes ☐ No

Occupation:

Employer:

Employer address:

Employer phone no.:

()

Stay @ home mom

Is this patient covered by insurance? ☒ Yes ☐ No

Please indicate primary insurance

Blue Cross / Medicaid

Coverage date:

Referral Information:

☐ Yes ☐ No

Length of service approved:

Follow up date:

Initial Referral Received

Subscriber's name:

Subscriber's S.S. no.:

Birth date:

Group no.:

Policy no.:

Co-pay:

\$

Patient's relationship to subscriber:

☐ Self☐ Spouse☐ Child☐ Other

Name of secondary insurance (if applicable):

Subscriber's name:

Group no.:

Policy no.:

Patient's relationship to subscriber:

☐ Self☐ Spouse☐ Child☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):

Relationship to patient:

Home phone no.:

Work phone no.:

()

()

Authorization for release of information: I authorize Kevin J. Sgroi, RPT, to release all medical information requested by my health insurance carrier, Me or any other third-party payers. I authorize Kevin J. Sgroi, RPT, to release all medical information to my referring physician and my primary (family) physician authorize Kevin J. Sgroi, RPT, to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage payments under my policy. I direct the insurance company or health plan administrator to release such information to Kevin J. Sgroi, RPT.

Assignment of Benefits: I request that payment of authorized insurance benefits be made on my behalf to Kevin J. Sgroi, RPT. I agree that these provisions remain in effect until I provide written revocation to Kevin J. Sgroi, RPT. I further agree that should my insurance carrier and/or health plan administrator deem my treatment, in full or part is not covered that I am responsible for all charges incurred as a result of treatment rendered by Kevin J. Sgroi, RPT and associated

Patient/Guardian signature

April Bryant

Date 3/16/09

CONFIDENTIAL INFORMATION

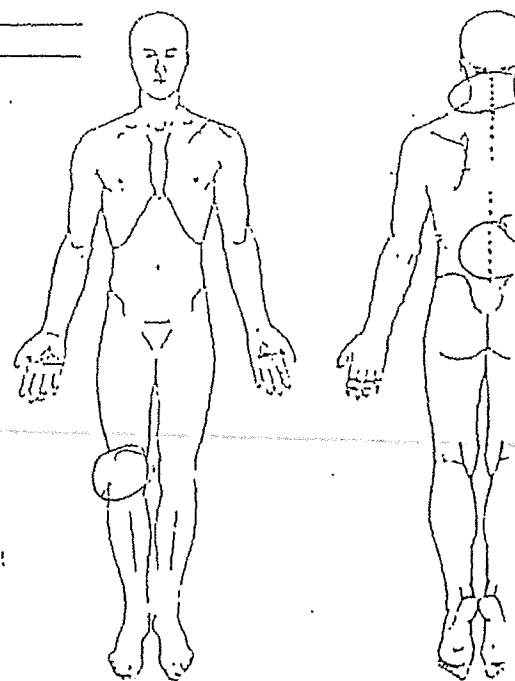
Welcome. We want to make your appointment as pleasant and comfortable as possible.
If at any time you have questions regarding your therapy session, please let us know.

NAME [REDACTED] HOME # 762-5619 WORK #
 ADDRESS 2417 E. St. James CITY Hayden STATE Id ZIP 83833
 DATE OF BIRTH [REDACTED] AGE M F ✓ MARITAL STATUS
 OCCUPATION REFERRED BY Dr. Westcott
 HAVE YOU EVER RECEIVED MASSAGE THERAPY? YES NO ✓
 TYPE OF MASSAGE EXPERIENCED: ☐ DEEP TISSUE ☐ SWEDISH ☐ OTHER
 ARE YOU TAKING MEDICATION? yes DESCRIBE HCTZ, Tylenol, oxydodone
 ARE YOU PREGNANT?
 HAVE YOU CONSUMED ALCOHOL IN THE PAST 24 HOURS? YES NO ✓

DO YOU HAVE A HISTORY OF THE FOLLOWING?

- | | | |
|---|---|--|
| <input type="checkbox"/> accident | <input type="checkbox"/> sprains | <input type="checkbox"/> mastectomy |
| <input checked="" type="checkbox"/> neck pain | <input type="checkbox"/> seizures | <input type="checkbox"/> breast augmentation |
| <input type="checkbox"/> whiplash | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> diabetes |
| <input checked="" type="checkbox"/> headaches | <input type="checkbox"/> nervous tension | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> shoulder pain | <input type="checkbox"/> arthritis, bursitis or | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> upper back pain | <input type="checkbox"/> gout | <input type="checkbox"/> stroke |
| <input type="checkbox"/> mid back pain | <input type="checkbox"/> allergies to oils or | <input type="checkbox"/> heart attack |
| <input checked="" type="checkbox"/> low back pain | <input type="checkbox"/> perfumes | <input type="checkbox"/> cancer |
| <input type="checkbox"/> joint aches | <input type="checkbox"/> wear contacts | <input type="checkbox"/> colitis |
| <input type="checkbox"/> decreased range | <input type="checkbox"/> scoliosis | <input type="checkbox"/> HIV |
| <input type="checkbox"/> of motion | <input checked="" type="checkbox"/> surgery | <input type="checkbox"/> <u></u> |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> <u></u> |
| <input type="checkbox"/> scoliosis | <input type="checkbox"/> carpal tunnel syndrome | |

PLEASE INDICATE WITH AN (X), THE
YOU ARE FEELING DISCOMFO



DO YOU HAVE ANY OF THE FOLLOWING TODAY:

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> sunburn | <input type="checkbox"/> open cuts, bruises, burns |
| <input type="checkbox"/> inflammation | <input type="checkbox"/> irritated skin rash |
| <input type="checkbox"/> severe pain | <input type="checkbox"/> poison ivy |
| <input type="checkbox"/> headache | <input type="checkbox"/> cold/flu |
| | <input type="checkbox"/> <u></u> |

WHAT ARE YOUR GOALS/EXPECTATIONS FOR THIS
THERAPY SESSION?

PLEASE READ THE FOLLOWING AND SIGN BELOW:

I understand that this message is not a replacement for medical care and that
no diagnosis will be made.

DATE: 3/16/09 SIGNATURE Dore Bryant

PRIVACY PRACTICES ACKNOWLEDGEMENT

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN
PROVIDED AN OPPORTUNITY TO REVIEW IT.

NAME April Bryant DATE OF BIRTH _____
SIGNATURE April Bryant DATE _____

Notification is required for inpatient admissions and prior authorization is required for selected hospitalization and non-hospitalization services. Call as soon as you know that you or your eligible dependents will be admitted. Failure to call may affect your benefit payments. Call (208) 331-7535 or 1-800-743-1871

WellPoint nextRX: 1-877-850-0180 BIN: 610053
(for location of participating pharmacy)

Customer Services: (208) 331-7347 or 1-800-627-1188

When you are outside the state of Idaho, call the BlueCard Access Number at: 1-800-810-2583 to locate a medical provider. HOSPITAL OR PHYSICIANS: Please file your claims with your local BlueCross BlueShield Plan.

Blue Cross of Idaho • P.O. Box 7408 • Boise, Idaho 83707
www.bcoidaho.com

Notification is required for inpatient admissions and prior authorization is required for selected hospitalization and non-hospitalization services. Call as soon as you know that you or your eligible dependents will be admitted. Failure to call may affect your benefit payments. Call (208) 331-7535 or 1-800-743-1871

WellPoint nextRX: 1-877-850-0180 BIN: 610053
(for location of participating pharmacy)

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When you are outside the state of Idaho, call the BlueCard Access Number at: 1-800-810-2583 to locate a medical provider. HOSPITAL OR PHYSICIANS: Please file your claims with your local BlueCross BlueShield Plan.

Blue Cross of Idaho • P.O. Box 7408 • Boise, Idaho 83707
www.bcoidaho.com



An Independent Licensee of the Blue Cross and Blue Shield Association

Managed Care	Enrollee Name	ID
	WAYNE E. BRYANT	2
Enrollee ID	BC/BS	Group #
XMH970191763	110610	10021090
PCP/Non-PCP		
\$20.00/\$40.00		

Preadmission Review required for all inpatient admissions

Eligibility for Health and Pharmacy Benefits

Member Name

Primary Care Physician
WESTCOTT, RONDA L.

*Will bring
Medicaid card in
+ Referral*

*Medicaid
#*

*1643066 Dr. Rhonda
Case # 85957 / Westcott
Walside
Pediatrics*

Bonnie Pilcher
Suite 201
1120 Ironwood Drive
Coeur D'Alene Id 83814



IDAHO DEPARTMENT OF
HEALTH & WELFARE

We provide interpreter services at no cost. If you need help reading this letter, please call us at 1-866-262-8640. After your call is answered, please wait on the line while you are connected with a translator.

Nosotros proveemos los servicios de un intérprete, sin costo alguno. Si necesita ayuda leyendo esta carta por favor llámenos al 1-866-262-8640. Cuando contesten su llamada, favor de esperar un momento en la línea mientras le conectan con un traductor.

[REDACTED]
2417 E St James
Hayden ID 83835

March 6, 2009

Case Number 859571

Important Information About
Your Child In-Home Health Care

Your Retroactive Health Coverage is approved:

November 2008 for [REDACTED]
December 2008 for —
☒ January 2009 for —

If you have been approved for Retroactive Health Coverage only, you will not get an Idaho Health Coverage Card. Please call me to get your Health Coverage Identification numbers.

If you don't agree with this decision about your application or case, please call me. We can review the facts used to make this decision together or you may ask for a hearing. In a hearing you and I tell a neutral person from outside Health and Welfare, called a hearing officer, about your case. This person will decide if the Department action on your case was correct.

You may ask for a hearing in writing or by calling me. If you make a hearing request in writing you may make a copy for your records. You may use a hearing request form from our office or just write on a piece of paper why you want a hearing. Then mail, fax, or bring your request to my office.

If you would like a hearing, you must make your request by April 5, 2009.

Bonnie Pilcher

208-769-1456 (phone) 208-666-6789 (fax)
pilcherb@dhw.idaho.gov

Wmed# 1643066

Routine For: [REDACTED]
 Created By: Kevin

Jun 30, 2009
 shoulder Bob Pritchard

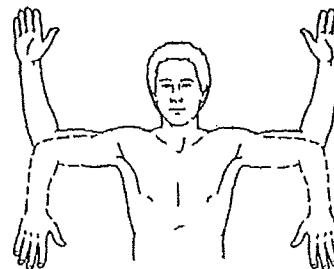
SHOULDER - 86 ROM:
 External / Internal Rotation – in Flexion (Standing)



With upper arms straight out in front and parallel to floor, keep elbows bent at right angles and rotate up then down as far as possible without pain.

Repeat 5 times per set. Do 3 sets per session.
 Do 1 sessions per day.

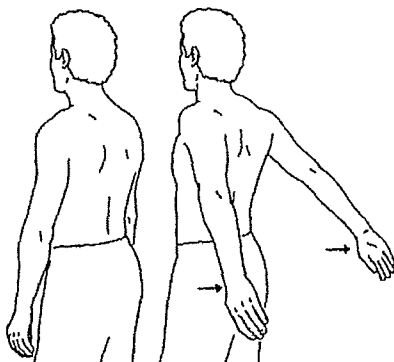
SHOULDER - 85 ROM:
 External / Internal Rotation – in Abduction (Standing)



With upper arms parallel to floor and elbows bent at right angles, gently rotate arms up then down as far as possible without pain.

Repeat 5 times per set. Do 3 sets per session.
 Do 1 sessions per day.

SHOULDER - 87 ROM: Extension (Standing)

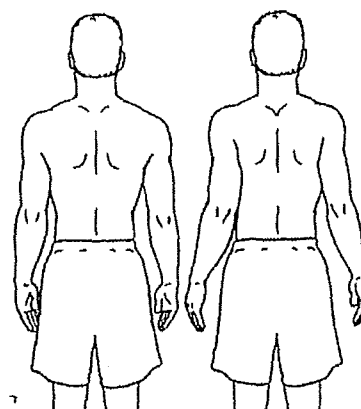


Bring arms straight back as far as possible without pain.

Repeat 5 times per set. Do 3 sets per session.
 Do 1 sessions per day.

SHOULDER - 101 Scapular Retraction (Standing)

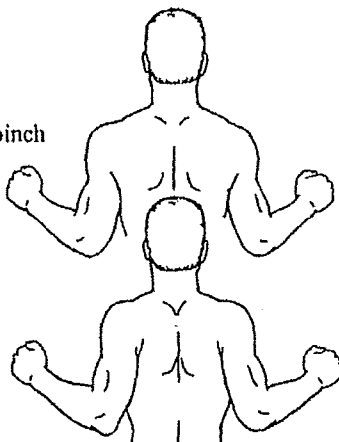
With arms at sides, pinch shoulder blades together.



Repeat 5 times per set.
 Do 3 sets per session.
 Do 1 sessions per day.

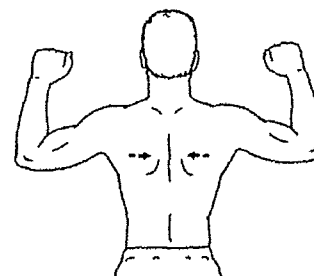
SHOULDER - 103 Scapular Retraction:
 Elbow Flexion (Standing)

With elbows bent to 90°, pinch shoulder blades together and rotate arms out, keeping elbows bent.



Repeat 5 times per set.
 Do 3 sets per session.
 Do 1 sessions per day.

SHOULDER - 104 Scapular Retraction:
 Abduction (Standing)



With arms elevated and elbows bent to 90°, pinch shoulder blades together and press arms back.

Repeat 5 times per set. Do 3 sets per session.
 Do 1 sessions per day.

CHART COPY

Routine For: [REDACTED]
 Created By: Kevin

Jun 30, 2009
 shoulder Bob Pritchard

SHOULDER - 86 ROM:
 External / Internal Rotation - in Flexion (Standing)



With upper arms straight out in front and parallel to floor, keep elbows bent at right angles and rotate up then down as far as possible without pain.

Repeat 5 times per set. Do 3 sets per session.
 Do 1 sessions per day.

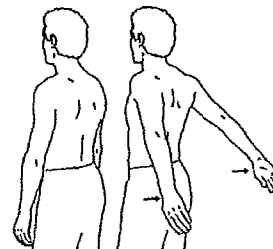
SHOULDER - 85 ROM:
 External / Internal Rotation - in Abduction (Standing)



With upper arms parallel to floor and elbows bent at right angles, gently rotate arms up then down as far as possible without pain.

Repeat 5 times per set. Do 3 sets per session.
 Do 1 sessions per day.

SHOULDER - 87 ROM: Extension (Standing)

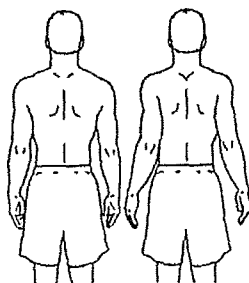


Bring arms straight back as far as possible without pain.

Repeat 5 times per set. Do 3 sets per session.
 Do 1 sessions per day.

SHOULDER - 101 Scapular Retraction (Standing)

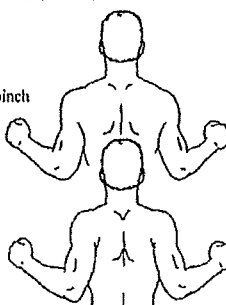
With arms at sides, pinch shoulder blades together.



Repeat 5 times per set.
 Do 3 sets per session.
 Do 1 sessions per day.

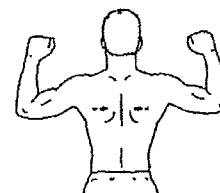
SHOULDER - 103 Scapular Retraction:
 Elbow Flexion (Standing)

With elbows bent to 90°, pinch shoulder blades together and rotate arms out, keeping elbows bent.



Repeat 5 times per set.
 Do 3 sets per session.
 Do 1 sessions per day.

SHOULDER - 104 Scapular Retraction:
 Abduction (Standing)



With arms elevated and elbows bent to 90°, pinch shoulder blades together and press arms back.

Repeat 5 times per set. Do 3 sets per session.
 Do 1 sessions per day.

		NAME: <i>[Redacted]</i>	SSN: <i>[Redacted]</i>
		DATE: <i>8/12/15</i>	DATE:
Subjective		<i>SEE IE</i>	
Objective		<i>SEE IE</i>	
NEURO Re-Ed		To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input checked="" type="checkbox"/> 25 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hi L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 mi OTHER:
Massage		To Musculature of: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Hip <input type="checkbox"/> Low Back <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To Musculature of: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:
Tape/TE		Kinesio tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> Leuko tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>	Kinesio tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> Leuko tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>
Ionto		To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x2 treatments <input type="checkbox"/> x24 minutes <input type="checkbox"/>	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> A Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x2 treatments <input type="checkbox"/> x24 minutes <input type="checkbox"/>
US		To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> W/CM2: .50 1.00 1.50 2.00 2.50	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> I L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> W/CM2: .50 1.00 1.50 2.00 2
Manual		To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> K TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:
Anodyne		To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> K TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:
MH/CP		To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elt Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:
Assessment		<i>Re measure for symmetry</i> <i>ⓑ I/O Body</i>	
Plan		<i>Held on by</i> <i>[Signature]</i> Kevin J. Sgroi, RPT	

Kevin J. Sgroi, RPT

Subjective	NAME: <u>6/1/09</u> ✓ DATE: <u>6/1/09</u> ✓	SSN: <u>[REDACTED]</u> DATE: <u>6/1/09</u> ✓
Objective	Pt Mom stated she had no pain since last Rx	
NEURO Re-Ed	No + - muscle Tightness to paraspinal	
Massage	To: C/S <input type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Low Back <input checked="" type="checkbox"/> Hip <input checked="" type="checkbox"/> R UE <input checked="" type="checkbox"/> L UE <input checked="" type="checkbox"/> R LE <input checked="" type="checkbox"/> L LE <input checked="" type="checkbox"/> Hand <input checked="" type="checkbox"/> Elbow <input checked="" type="checkbox"/> Wrist <input checked="" type="checkbox"/> Knee <input checked="" type="checkbox"/> Ankle <input checked="" type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> OTHER:
Tape/TE	To Musculature of: C/S <input checked="" type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Hip <input checked="" type="checkbox"/> Low Back <input checked="" type="checkbox"/> R UE <input checked="" type="checkbox"/> L UE <input checked="" type="checkbox"/> R LE <input checked="" type="checkbox"/> L LE <input checked="" type="checkbox"/> Hand <input checked="" type="checkbox"/> Wrist <input checked="" type="checkbox"/> Elbow <input checked="" type="checkbox"/> Knee <input checked="" type="checkbox"/> Ankle <input checked="" type="checkbox"/> TIME: 20 min <input checked="" type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To Musculature of: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Hip <input type="checkbox"/> Low Back <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:
Tape/TE	Kinesio tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> Leuko tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>	Kinesio tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> Leuko tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>
Tape/TE	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x2 treatments <input type="checkbox"/> x24 minutes <input type="checkbox"/>	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x2 treatments <input type="checkbox"/> x24 minutes <input type="checkbox"/>
US	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> W/CM2: .50 1.00 1.50 2.00 2.50	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> W/CM2: .50 1.00 1.50 2.00 2.50
Manual	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:
Anodyne	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:
MH/CP	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:
Assessment	Pt still has mild pain no c/o of pain since last Rx	
Plan	Cont'd current doc	
Plan	Kevin J. Sgroi, RPT	Kevin J. Sgroi, RPT

	NAME: <u>6/4/09</u>	SSN: <u>6-9-09</u> ✓
Subjective	Pt Dad stated <u>has not had a HA since last R</u>	Pt Mom stated <u>has had 7 in HA per few days</u>
Objective	Pt not as fatigued today	Pt had minor <u>muscle tension to para Spinal</u>
NEURO Re-Ed	To: C/S <input type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Low Back <input checked="" type="checkbox"/> Hip <input checked="" type="checkbox"/> R UE <input checked="" type="checkbox"/> L UE <input checked="" type="checkbox"/> R LE <input checked="" type="checkbox"/> L LE <input checked="" type="checkbox"/> Hand <input checked="" type="checkbox"/> Elbow <input checked="" type="checkbox"/> Wrist <input checked="" type="checkbox"/> Knee <input checked="" type="checkbox"/> Ankle <input checked="" type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input checked="" type="checkbox"/> 25 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Low Back <input checked="" type="checkbox"/> Hip <input checked="" type="checkbox"/> R UE <input checked="" type="checkbox"/> L UE <input checked="" type="checkbox"/> R LE <input checked="" type="checkbox"/> L LE <input checked="" type="checkbox"/> Hand <input checked="" type="checkbox"/> Elbow <input checked="" type="checkbox"/> Wrist <input checked="" type="checkbox"/> Kne <input checked="" type="checkbox"/> Ankle <input checked="" type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input checked="" type="checkbox"/> 25 <input type="checkbox"/> OTHER
Massage	To Musculature of: C/S <input checked="" type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Hip <input checked="" type="checkbox"/> Low Back <input checked="" type="checkbox"/> R UE <input checked="" type="checkbox"/> L UE <input checked="" type="checkbox"/> R LE <input checked="" type="checkbox"/> L LE <input checked="" type="checkbox"/> Hand <input checked="" type="checkbox"/> Wrist <input checked="" type="checkbox"/> Elbow <input checked="" type="checkbox"/> Knee <input checked="" type="checkbox"/> Ankle <input checked="" type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input checked="" type="checkbox"/> 30 min <input type="checkbox"/> OTHER: <u>CA</u>	To Musculature of: C/S <input checked="" type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Hip <input checked="" type="checkbox"/> Low Back <input checked="" type="checkbox"/> R UE <input checked="" type="checkbox"/> L UE <input checked="" type="checkbox"/> R LE <input checked="" type="checkbox"/> L LE <input checked="" type="checkbox"/> Han <input checked="" type="checkbox"/> Wrist <input checked="" type="checkbox"/> Elbow <input checked="" type="checkbox"/> Knee <input checked="" type="checkbox"/> Ankle <input checked="" type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input checked="" type="checkbox"/> 30 min <input type="checkbox"/> OTHER: <u>CA</u>
Tape/TE	Kinesio tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> Leuko tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>	Kinesio tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> Leuko tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>
Intro	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x2 treatments <input type="checkbox"/> x24 minutes <input type="checkbox"/>	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Kne <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x2 treatments <input type="checkbox"/> x24 minutes <input type="checkbox"/>
US	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> W/CM2: .5 <input type="checkbox"/> 1.0 <input type="checkbox"/> 1.5 <input type="checkbox"/> 2.0 <input type="checkbox"/> 2.5 <input type="checkbox"/>	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Kne <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 2. W/CM2: .5 <input type="checkbox"/> 1.0 <input type="checkbox"/> 1.5 <input type="checkbox"/> 2.0 <input type="checkbox"/> 2.5 <input type="checkbox"/>
Manual	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> . TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:
Anodyne	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Low Back <input checked="" type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Low Back <input checked="" type="checkbox"/> Hip <input type="checkbox"/> F L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> , TIME: 30 min <input checked="" type="checkbox"/> 45 min <input type="checkbox"/> OTHER:
MH/CP	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> V Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:
Assessment	Pt tot R well had no C10 per PR	Pt tot R well had no C10 HA PR
Plan	Cont current PR <u>Kevin J. Sgroi, RPT</u>	Cont current PR <u>Kevin J. Sgroi, RPT</u>

	NAME: [REDACTED] DATE: 5/14/09	SSN: [REDACTED] DATE: 6/2/09
Subjective	Pt. Mom stated [REDACTED] was playing for ~ 1 1/2 hrs then no severe HA	Pt's dad stated he w/A here and since NOT having PT
Objective	No significant muscle tension to back	Pt very fatigued T600g
NEURO Re-Ed	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> OTHER:
Massage	To Musculature of: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Hip <input type="checkbox"/> Low Back <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To Musculature of: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER: ITB + PIRIFORMIS
Tape/TE	Kinesio tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> Leuko tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>	Kinesio tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> Leuko tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>
Intro	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x2 treatments <input type="checkbox"/> x24 minutes <input type="checkbox"/>	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x2 treatments <input type="checkbox"/> x24 minutes <input type="checkbox"/>
US	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> W/CM2: .50 <input type="checkbox"/> 1.00 <input type="checkbox"/> 1.50 <input type="checkbox"/> 2.00 <input type="checkbox"/> 2.50 <input type="checkbox"/>	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> W/CM2: .50 <input type="checkbox"/> 1.00 <input type="checkbox"/> 1.50 <input type="checkbox"/> 2.00 <input type="checkbox"/> 2.50 <input type="checkbox"/>
Manual	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:
Anodyne	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:
MH/CP	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:
Assessment	Pt. Momwell had no c/o HA PR	Pt. Momwell had no c/o HA PR
Plan	Cont to current pt KJ Sgroi, PT	Cont to current pt KJ Sgroi, PT

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

	NAME: 5/7/09	SSN: [REDACTED]	DATE: 5/12/09
Subjective	Pt stated she was Tired Today	Pt mother stated [REDACTED] has not had any HA since last	
Objective	Pt to have Photo Taken Today	No + in muscle Tension to back	
NEURO Re-Ed	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> K Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> OTHER:	
Massage	To Musculature of: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Hip <input type="checkbox"/> Low Back <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To Musculature of: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Hip <input type="checkbox"/> Low Back <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> H Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER: Glutes, ITB, Piriformis	
Tape/TE	Kinesio tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> Leuko tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>	Kinesio tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> Leuko tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>	
Ionto	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x2 treatments <input type="checkbox"/> x24 minutes <input type="checkbox"/>	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x2 treatments <input type="checkbox"/> x24 minutes <input type="checkbox"/>	
US	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> W/CM2: .50 <input type="checkbox"/> 1.00 <input type="checkbox"/> 1.50 <input type="checkbox"/> 2.00 <input type="checkbox"/> 2.50 <input type="checkbox"/>	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> W/CM2: .50 <input type="checkbox"/> 1.00 <input type="checkbox"/> 1.50 <input type="checkbox"/> 2.00 <input type="checkbox"/> 2.50 <input type="checkbox"/>	
Manual	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	
Anodyne	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:	
MH/CP	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:	
Assessment	Pt not R-mella little tired P/R	Pt not R-mella no C/O pain P/R	
Plan	Cont c current POC [Signature]	Cont c current POC [Signature]	

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

	NAME: [REDACTED] DATE: 1/30/09	SS: [REDACTED] DATE: 5/5/09 ✓
Subjective	Pt non stated her Shunt is draining to much CSF	Pt stated [REDACTED] is going to have her Shunt removed next week
Objective	No muscle tension to low back movement	No signif Δ noted
NEURO Re-Ed	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> OTHER:
Massage	To Musculature of: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Hip <input type="checkbox"/> Low Back <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER: ITB & Perforis	To Musculature of: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER: ITB & Glutes
Tape/TE	Kinesio tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> Leuko tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>	Kinesio tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> Leuko tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>
Ionio	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x2 treatments <input type="checkbox"/> x24 minutes <input type="checkbox"/>	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x2 treatments <input type="checkbox"/> x24 minutes <input type="checkbox"/>
US	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> W/CM2: .5 <input type="checkbox"/> 1.0 <input type="checkbox"/> 1.5 <input type="checkbox"/> 2.0 <input type="checkbox"/> 2.5 <input type="checkbox"/>	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> W/CM2: .5 <input type="checkbox"/> 1.0 <input type="checkbox"/> 1.5 <input type="checkbox"/> 2.0 <input type="checkbox"/> 2.5 <input type="checkbox"/>
Manual	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:
Anodyne	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:
M/CP	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:
Assessment	Pt talk well had no C/O per PR	Pt talk well had no C/O H/H PR
Plan	Cont current PR [Signature]	Cont current PR [Signature]

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

	NAME: DATE: 4/23/09	SSN: DATE: 4/28/09 ✓
Subjective	Pt Mon stated [redacted] has been sick past few wks	Pt stated she does not have as many wks
Objective	No signif + muscle tension to back	No + in muscle tension to back
NEURO Re-Ed	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 10 min □ 15 min □ 20 min □ 25 min □ OTHER:	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 10 min □ 15 min □ 20 min □ 25 min □ OTHER:
Massage	To Musculature of: C/S□ Shoulders□ Mid Back□ Hip□ Low Back□ R UE□ L UE□ R LE□ L LE□ Hand□ Wrist□ Elbow□ Knee□ Ankle□ TIME: 20 min □ 25 min □ 30 min □ OTHER: Gluts, ITB, Piriformis	To Musculature of: C/S□ Shoulders□ Mid Back□ Hip□ Low Back□ R UE□ L UE□ R LE□ L LE□ Hand□ Wrist□ Elbow□ Knee□ Ankle□ TIME: 20 min □ 25 min □ 30 min □ OTHER:
Tape/TE	Kinesio tape: x1 □ x2 □ x3 □ Leuko tape: x1 □ x2 □ x3 □ THERAPEUTIC EXERCISES: 15 min □ 30 min □ 45 min □ See Flow Sheet 60 min □	Kinesio tape: x1 □ x2 □ x3 □ Leuko tape: x1 □ x2 □ x3 □ THERAPEUTIC EXERCISES: 15 min □ 30 min □ 45 min □ See Flow Sheet 60 min □
Ionto	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ Dexamethasone □ Acetic Acid □ x1 treatment □ x2 treatments □ x24 minutes □	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ Dexamethasone □ Acetic Acid □ x1 treatment □ x2 treatments □ x24 minutes □
US	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 10 min □ 15 min □ 20 min □ 25 min □ W/CM2: .50 1.00 1.50 2.00 2.50	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 10 min □ 15 min □ 20 min □ 25 min □ W/CM2: .50 1.00 1.50 2.00 2.50
Manual	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 15 min □ 20 min □ 25 min □ 30 min □ OTHER:	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 15 min □ 20 min □ 25 min □ 30 min □ OTHER:
Anodyne	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 30 min □ 45 min □ OTHER:	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 30 min □ 45 min □ OTHER:
MI/CP	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 20 min □ OTHER:	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 20 min □ OTHER:
Assessment	Pt still R well had no C/O pain p R	Pt still R well had no C/O pain p R
Plan	Cont c current p R [Signature]	Cont c current p R [Signature]
	Kevin J. Sgroi, RPT	Kevin J. Sgroi, RPT

	NAME: 3/24/09	SSN: [REDACTED]	DATE: 3/26/09
Subjective	Pt mother stated [REDACTED] did not have HA for 4-5 days	Pt has no HA since last visit	
Objective	No muscle tension C/S	Minor muscle tension to back	
NEURO Re-Ed	To: C/S <input checked="" type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input checked="" type="checkbox"/> 25 min <input type="checkbox"/> OTHER:	To: C/S <input checked="" type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R U <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input checked="" type="checkbox"/> 25 min <input type="checkbox"/> OTHER:	
Massage	To Musculature of: C/S <input checked="" type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Hip <input checked="" type="checkbox"/> Low Back <input checked="" type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input checked="" type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To Musculature of: C/S <input checked="" type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Hip <input checked="" type="checkbox"/> Low Back <input checked="" type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input checked="" type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	
Tape/TE	Kinesio tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> Leuko tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>	Kinesio tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> Leuko tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>	
Ionto	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x 2 treatments <input type="checkbox"/> x 24 minutes <input type="checkbox"/>	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x 2 treatments <input type="checkbox"/> x 24 minutes <input type="checkbox"/>	
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Manual	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> A <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	
Anodyne	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> A <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:	
MI/CP	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> W <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:	
Assessment	Pt has well had no C/O HA pain & R	Pt has well had no C/O pain & R	
Plan	Cont to current doc [Signature]	Cont to current doc [Signature]	

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

	NAME: [REDACTED]	SSN: [REDACTED]
	DATE: 3/16/09 ✓	DATE: 3/19/09 ✓
Subjective	SEE IE	Pt from stated [REDACTED] had a H/A for = 2 days to last R. NO D/C, H/A today
Objective	SEE IE	NO signif AS - muscle tension
NEURO Re-Ed	To: C/S <input checked="" type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Low Back <input checked="" type="checkbox"/> Hip <input checked="" type="checkbox"/> R UE <input checked="" type="checkbox"/> L UE <input checked="" type="checkbox"/> R LE <input checked="" type="checkbox"/> L LE <input checked="" type="checkbox"/> Hand <input checked="" type="checkbox"/> Elbow <input checked="" type="checkbox"/> Wrist <input checked="" type="checkbox"/> Knee <input checked="" type="checkbox"/> Ankle <input checked="" type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> OTHER:	To: C/S <input checked="" type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Low Back <input checked="" type="checkbox"/> Hi L UE <input checked="" type="checkbox"/> R LE <input checked="" type="checkbox"/> L LE <input checked="" type="checkbox"/> Hand <input checked="" type="checkbox"/> Elbow <input checked="" type="checkbox"/> Wrist <input checked="" type="checkbox"/> Ankle <input checked="" type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> OTHER:
Massage	To Musculature of: C/S <input checked="" type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Hip <input checked="" type="checkbox"/> Low Back <input checked="" type="checkbox"/> R UE <input checked="" type="checkbox"/> L UE <input checked="" type="checkbox"/> R LE <input checked="" type="checkbox"/> L LE <input checked="" type="checkbox"/> Hand <input checked="" type="checkbox"/> Wrist <input checked="" type="checkbox"/> Elbow <input checked="" type="checkbox"/> Knee <input checked="" type="checkbox"/> Ankle <input checked="" type="checkbox"/> TIME: 20 min <input checked="" type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To Musculature of: C/S <input checked="" type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Low Back <input checked="" type="checkbox"/> R UE <input checked="" type="checkbox"/> L UE <input checked="" type="checkbox"/> R LE <input checked="" type="checkbox"/> L LE <input checked="" type="checkbox"/> Wrist <input checked="" type="checkbox"/> Elbow <input checked="" type="checkbox"/> Knee <input checked="" type="checkbox"/> Ankle <input checked="" type="checkbox"/> HIPS TIME: 20 min <input checked="" type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:
Tape/TE	Kinesio tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> Leuko tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>	Kinesio tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> Leuko tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>
Intro	To: C/S <input checked="" type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Low Back <input checked="" type="checkbox"/> Hip <input checked="" type="checkbox"/> R UE <input checked="" type="checkbox"/> L UE <input checked="" type="checkbox"/> R LE <input checked="" type="checkbox"/> L LE <input checked="" type="checkbox"/> Hand <input checked="" type="checkbox"/> Elbow <input checked="" type="checkbox"/> Wrist <input checked="" type="checkbox"/> Knee <input checked="" type="checkbox"/> Ankle <input checked="" type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x2 treatments <input type="checkbox"/> x24 minutes <input type="checkbox"/>	To: C/S <input checked="" type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Low Back <input checked="" type="checkbox"/> R UE <input checked="" type="checkbox"/> L UE <input checked="" type="checkbox"/> R LE <input checked="" type="checkbox"/> L LE <input checked="" type="checkbox"/> Hand <input checked="" type="checkbox"/> Elbow <input checked="" type="checkbox"/> V Ankle <input checked="" type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x2 treatments <input type="checkbox"/> x24 minutes <input type="checkbox"/>
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Manual	To: C/S <input checked="" type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Low Back <input checked="" type="checkbox"/> Hip <input checked="" type="checkbox"/> R UE <input checked="" type="checkbox"/> L UE <input checked="" type="checkbox"/> R LE <input checked="" type="checkbox"/> L LE <input checked="" type="checkbox"/> Hand <input checked="" type="checkbox"/> Elbow <input checked="" type="checkbox"/> Wrist <input checked="" type="checkbox"/> Knee <input checked="" type="checkbox"/> Ankle <input checked="" type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To: C/S <input checked="" type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Low Back <input checked="" type="checkbox"/> I L UE <input checked="" type="checkbox"/> R LE <input checked="" type="checkbox"/> L LE <input checked="" type="checkbox"/> Hand <input checked="" type="checkbox"/> Elbow <input checked="" type="checkbox"/> Wrist <input checked="" type="checkbox"/> K TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:
Analyne	To: C/S <input checked="" type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Low Back <input checked="" type="checkbox"/> Hip <input checked="" type="checkbox"/> R UE <input checked="" type="checkbox"/> L UE <input checked="" type="checkbox"/> R LE <input checked="" type="checkbox"/> L LE <input checked="" type="checkbox"/> Hand <input checked="" type="checkbox"/> Elbow <input checked="" type="checkbox"/> Wrist <input checked="" type="checkbox"/> Knee <input checked="" type="checkbox"/> Ankle <input checked="" type="checkbox"/> TIME: 30 min <input checked="" type="checkbox"/> 45 min <input type="checkbox"/> OTHER:	To: C/S <input checked="" type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Low Back <input checked="" type="checkbox"/> : L UE <input checked="" type="checkbox"/> R LE <input checked="" type="checkbox"/> L LE <input checked="" type="checkbox"/> Hand <input checked="" type="checkbox"/> Elbow <input checked="" type="checkbox"/> Wrist <input checked="" type="checkbox"/> K TIME: 30 min <input checked="" type="checkbox"/> 45 min <input type="checkbox"/> OTHER:
MH/CP	To: C/S <input checked="" type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Low Back <input checked="" type="checkbox"/> Hip <input checked="" type="checkbox"/> R UE <input checked="" type="checkbox"/> L UE <input checked="" type="checkbox"/> R LE <input checked="" type="checkbox"/> L LE <input checked="" type="checkbox"/> Hand <input checked="" type="checkbox"/> Elbow <input checked="" type="checkbox"/> Wrist <input checked="" type="checkbox"/> Knee <input checked="" type="checkbox"/> Ankle <input checked="" type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:	To: C/S <input checked="" type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Low Back <input checked="" type="checkbox"/> R UE <input checked="" type="checkbox"/> L UE <input checked="" type="checkbox"/> R LE <input checked="" type="checkbox"/> L LE <input checked="" type="checkbox"/> Hand <input checked="" type="checkbox"/> Elb Knee <input checked="" type="checkbox"/> Ankle <input checked="" type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:
Assessment	Pt sat R well. Had no C/O H/A P/R	Pt sat R well. Had no C/O H/A P/R
Plan	Cont to current POC [Signature]	Cont to current POC [Signature]

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT



STYLE OF
CASE :

[REDACTED]

vs.

MILHORAT, M.D., et al.

PERTAIN TO :

[REDACTED]

FROM : Joshua Tree Physical Therapy (incl. Kevin Sigroi, M.D.) (Medical
Records Update)

DELIVER TO :

Christina Ctorides
Goldsmith Ctorides & Rodriguez, LLP.
140 Sylvan Avenue, 3rd Floor
Englewood Cliffs, NJ 07632

CASE NO.:

COURT:

Order No. 102305.020

No.

vs.

MILHORAT, M.D., et al.

§
§
§
§
§
§
§

AFFIDAVIT

Records Pertaining To:

Type of Records:

ANY AND ALL MEDICAL RECORDS FROM 01/01/2010 TO THE PRESENT, including but not limited to patient information sheets, patient questionnaires, medical history forms, consents for treatment, and any other type of "new patient" documentation; doctor's notes; nurse's notes; patient evaluation forms; narratives; insurance records; photographs; reports; office notes; prescription records and/or documentation related to medication administration; test results; physical therapy, occupational therapy and/or speech therapy records; correspondence; files and/or charts; telephone message slips; copies of any type of notation(s) on any file folder

Before me, the undersigned authority, personally appeared
who, being by me duly sworn, deposed as follows:

Bonnie Burrage
(Custodian of Records)

My name is Bonnie Burrage, I am over eighteen (18) years of age, of sound mind, capable of making this affidavit, and personally acquainted with the facts herein stated:

I am the Custodian of Records for:
Joshua Tree Physical Therapy (incl. Kevin Sigroi, M.D.)

Attached hereto are 21 pages of records from this facility. These records are kept in the regular course of business, and it was the regular course of business for an employee or representative of this facility, with knowledge of the act, event, condition, opinion, or diagnosis, recorded to make the record or to transmit information thereof to be included in such record; and the record was made at or near the time or reasonably soon thereafter. The records attached hereto are the original or exact duplicates of the original.

B. Burrage
AFFIANT (Custodian of Records)

Sworn to and subscribed before me on the 9th day of May, 2014.



John J. Simon
NOTARY PUBLIC

My Commission Expires: May 16, 2014

Table of Contents

	Image Page No.
001-MEDICAL-RECORDS.....	1

Name: 4/26/11 ✓		Date: 4/28/11 ✓
SUBJECTIVE	Pt had no c/o r pain since last R	Pt c/o Tingling in ft only
OBJECTIVE	Pt Mon started c/o r - Tingling B. Hands	No c/o Tingling in hands
NEURO RE-ED	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ 30 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ 30 MIN □ OTHER:
MASSAGE	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: FA	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: FA
TAPE/TE	KINESIO TAPE: *1 □ *2 □ *3 □ LEUKO TAPE: *1 □ *2 □ *3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET	KINESIO TAPE: *1 □ *2 □ *3 □ LEUKO TAPE: *1 □ *2 □ *3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET
IONTO	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ *1 TREATMENT □ *2 TREATMENTS □ *24 MINUTES □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ *1 TREATMENT □ *2 TREATMENTS □ *24 MINUTES □
US	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □
MANUAL	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:
ANODYNE	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:
MH/CP	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:
OTHER	IFC *20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □	IFC *20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □
ASSESSMENT	Pt sat R well had no c/o pain R	Pt sat R well had no c/o Tingling R
PLAN	Cont c current fac K. J. Sgroi, RPT	Cont c current fac K. J. Sgroi, RPT

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

modality sheet

Name: <u>3/17/11</u>		Date: <u>4/21/11</u> ✓	
SUBJECTIVE	Pt stated the lase is feeling better		Pt c/o back pain = 4-5/10
OBJECTIVE	No signif AS in muscle tension		Pt has been in N.Y. post two wk's
NEURO RE-ED	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> OTHER:		TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> OTHER:
MASSAGE	TO MUSCULATURE OF: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 40 MIN <input type="checkbox"/> OTHER: <u>FA</u>		TO MUSCULATURE OF: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 40 MIN <input type="checkbox"/> OTHER: <u>FA</u>
TAPE/TE	KINESIO TAPE: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> LEUKO TAPE: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> 60 MIN <input type="checkbox"/> SEE FLOW SHEET		KINESIO TAPE: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> LEUKO TAPE: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> 60 MIN <input type="checkbox"/> SEE FLOW SHEET
IONTO	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> DEXAMETHASONE <input type="checkbox"/> ACETIC ACID <input type="checkbox"/> *1 TREATMENT <input type="checkbox"/> *2 TREATMENTS <input type="checkbox"/> *24 MINUTES <input type="checkbox"/>		TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> DEXAMETHASONE <input type="checkbox"/> ACETIC ACID <input type="checkbox"/> *1 TREATMENT <input type="checkbox"/> *2 TREATMENTS <input type="checkbox"/> *24 MINUTES <input type="checkbox"/>
US	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> W/CM2: .5 <input type="checkbox"/> 1.0 <input type="checkbox"/> 1.5 <input type="checkbox"/> 2.0 <input type="checkbox"/> 2.5 <input type="checkbox"/>		TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> W/CM2: .5 <input type="checkbox"/> 1.0 <input type="checkbox"/> 1.5 <input type="checkbox"/> 2.0 <input type="checkbox"/> 2.5 <input type="checkbox"/>
MANUAL	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:		TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:
ANODYNE	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> OTHER:		TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> OTHER:
MH/CP	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:		TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:
OTHER	IFC <input type="checkbox"/> 20 MINUTES <input type="checkbox"/> LASER <input type="checkbox"/> THERAPEUTIC ACTIVITY <input type="checkbox"/> OTHER <input type="checkbox"/>		IFC <input type="checkbox"/> 20 MINUTES <input type="checkbox"/> LASER <input type="checkbox"/> THERAPEUTIC ACTIVITY <input type="checkbox"/> OTHER <input type="checkbox"/>
ASSESSMENT	Pt still well had no c/o pain to		Pt still well c/o pain ↓ to = to PR
PLAN	Cont c current for		Cont c current for

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

modality sheet

Name: 2/17/11
Date: 3/3/11Date: 3/3/11

SUBJECTIVE	PT stated she has had tingling in her hands	PT cont to have tingling in feet
OBJECTIVE	No 1's in joint segment	Minor 1's in muscle tension low back
NEURO RE-ED	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:
MASSAGE	TO MUSCULATURE OF: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 40 MIN <input type="checkbox"/> OTHER: FA	TO MUSCULATURE OF: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 40 MIN <input type="checkbox"/> OTHER: FA
TAPE/TE	KINESIO TAPE: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> LEUKO TAPE: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> 60 MIN <input type="checkbox"/> SEE FLOW SHEET	KINESIO TAPE: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> LEUKO TAPE: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> 60 MIN <input type="checkbox"/> SEE FLOW SHEET
IONTO	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> DEXAMETHASONE <input type="checkbox"/> ACETIC ACID <input type="checkbox"/> *1 TREATMENT <input type="checkbox"/> *2 TREATMENTS <input type="checkbox"/> *24 MINUTES <input type="checkbox"/>	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> DEXAMETHASONE <input type="checkbox"/> ACETIC ACID <input type="checkbox"/> *1 TREATMENT <input type="checkbox"/> *2 TREATMENTS <input type="checkbox"/> *24 MINUTES <input type="checkbox"/>
US	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> W/CM2: .5 <input type="checkbox"/> 1.0 <input type="checkbox"/> 1.5 <input type="checkbox"/> 2.0 <input type="checkbox"/> 2.5 <input type="checkbox"/>	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> W/CM2: .5 <input type="checkbox"/> 1.0 <input type="checkbox"/> 1.5 <input type="checkbox"/> 2.0 <input type="checkbox"/> 2.5 <input type="checkbox"/>
MANUAL	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:
ANODYNE	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> OTHER:
MP/CP	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:
OTHER	IFC <input type="checkbox"/> 20 MINUTES <input type="checkbox"/> LASER <input type="checkbox"/> THERAPEUTIC ACTIVITY <input type="checkbox"/> OTHER:	IFC <input type="checkbox"/> 20 MINUTES <input type="checkbox"/> LASER <input type="checkbox"/> THERAPEUTIC ACTIVITY <input type="checkbox"/> OTHER:
ASSESSMENT	PT still has well had no C10 pain P/R	PT still has well had no C10 tingling P/R
PLAN	Cont to current POC KJG/1/11	Cont to current POC KJG/1/11

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

modality sheet

Name:	2/10/11	Date:	2/10/11
SUBJECTIVE	Pt had no c/o red pain since last R	Pt had no c/o red pain since last R	
OBJECTIVE	No signif L - gait sequence	No T - muscle Tension Low Back	
NEURO RE-ED	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ 30 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ 30 MIN □ OTHER:	
MASSAGE	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: FA	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: FA	
TAPE/TE	KINESIO TAPE: ×1 □ ×2 □ ×3 □ LEUKO TAPE: ×1 □ ×2 □ ×3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET	KINESIO TAPE: ×1 □ ×2 □ ×3 □ LEUKO TAPE: ×1 □ ×2 □ ×3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET	
IONTO	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ ×1 TREATMENT □ ×2 TREATMENTS □ ×24 MINUTES □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ ×1 TREATMENT □ ×2 TREATMENTS □ ×24 MINUTES □	
US	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □	
MANUAL	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:	
ANODYNE	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:	
MH/CP	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:	
OTHER	IFC × 20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □	IFC × 20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □	
	Pt had no c/o pain FR	Pt still well had no c/o pain FR	
	Cont & current doc J. Sgroi, PT	Cont & current doc J. Sgroi, PT	

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

modality sheet

Name: 1/25/11
Date:Date: 2/1/11

SUBJECTIVE	Pt was to pneumonia c/o 7 x BP. May be to 7 coughing	Pt Mom stated Tugly in pt has ↓. No c/o r/h since last
OBJECTIVE	Mod 7 muscle tension Low Back	2 BP = $\frac{3}{10}$
NEURO RE-ED	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ 30 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ 30 MIN □ OTHER:
MASSAGE	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER:	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: PA
TAPE/TE	KINESIO TAPE: ×1 □ ×2 □ ×3 □ LEUKO TAPE: ×1 □ ×2 □ ×3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET	KINESIO TAPE: ×1 □ ×2 □ ×3 □ LEUKO TAPE: ×1 □ ×2 □ ×3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET
IONTO	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ ×1 TREATMENT □ ×2 TREATMENTS □ ×24 MINUTES □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ ×1 TREATMENT □ ×2 TREATMENTS □ ×24 MINUTES □
US	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □
MANUAL	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:
ANODYNE	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:
MH/CP	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:
OTHER	IFC × 20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □	IFC × 20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □
ASSESSMENT	Pt tol R neck had no c/o pain T R	Pt tol R neck c/o 1 BP ↓ to = to T R
	Cont to current rx KJ Sgroi, PT	Cont to current rx KJ Sgroi, PT

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

modality sheet

Name: Date:	1/11/11	Date: 1/18/11
SUBJECTIVE	Pt c/o Tingling @ ft. Since last tx	Pt still c/o Tingling @ ft. Also c/o a sensation as if H ₂ O
OBJECTIVE	No + - a tatoo got	is running down the back of her legs
NEURO RE-ED	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:
MASSAGE	TO MUSCULATURE OF: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 40 MIN <input type="checkbox"/> OTHER: FA	TO MUSCULATURE OF: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 40 MIN <input type="checkbox"/> OTHER: LC
TAPE/TE	KINESIO TAPE: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> LEUKO TAPE: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> 60 MIN <input type="checkbox"/> SEE FLOW SHEET	KINESIO TAPE: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> LEUKO TAPE: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> 60 MIN <input type="checkbox"/> SEE FLOW SHEET
IONTO	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> DEXAMETHASONE <input type="checkbox"/> ACETIC ACID <input type="checkbox"/> *1 TREATMENT <input type="checkbox"/> *2 TREATMENTS <input type="checkbox"/> *24 MINUTES <input type="checkbox"/>	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> DEXAMETHASONE <input type="checkbox"/> ACETIC ACID <input type="checkbox"/> *1 TREATMENT <input type="checkbox"/> *2 TREATMENTS <input type="checkbox"/> *24 MINUTES <input type="checkbox"/>
US	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> W/CM2: .5 <input type="checkbox"/> 1.0 <input type="checkbox"/> 1.5 <input type="checkbox"/> 2.0 <input type="checkbox"/> 2.5 <input type="checkbox"/>	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> W/CM2: .5 <input type="checkbox"/> 1.0 <input type="checkbox"/> 1.5 <input type="checkbox"/> 2.0 <input type="checkbox"/> 2.5 <input type="checkbox"/>
MANUAL	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:
ANODYNE	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> OTHER:
MH/CP	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:
OTHER	IFC <input type="checkbox"/> 20 MINUTES <input type="checkbox"/> LASER <input type="checkbox"/> THERAPEUTIC ACTIVITY <input type="checkbox"/> OTHER:	IFC <input type="checkbox"/> 20 MINUTES <input type="checkbox"/> LASER <input type="checkbox"/> THERAPEUTIC ACTIVITY <input type="checkbox"/> OTHER:
ASSESSMENT	Pt still c/o well c/o Tingling @ ft	Pt still c/o well had no c/o para ft
..	Cont to current doc K J Sgroi, RPT	Cont to current doc K J Sgroi, RPT

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

modality sheet

Name:
 Date: 12/14/10

Date: 1/4/10

SUBJECTIVE	pt had no c/o and pt / 1/4 mile last R	pt c/o and HAs over past 2 wk. also c/o tugling @ ft & leg.
OBJECTIVE	No T in muscle Tension c/s / pain last	pt stated after playing for a little while @ LES become very tired
NEURO RE-ED	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:
MASSAGE	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: FA	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: FA
TAPE/TE	KINESIO TAPE: *1 □ *2 □ *3 □ LEUKO TAPE: *1 □ *2 □ *3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET	KINESIO TAPE: *1 □ *2 □ *3 □ LEUKO TAPE: *1 □ *2 □ *3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET
IONTO	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ *1 TREATMENT □ *2 TREATMENTS □ *24 MINUTES □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ *1 TREATMENT □ *2 TREATMENTS □ *24 MINUTES □
US	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □
MANUAL	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:
ANODYNE	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:
MISC	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:
OTHER	IFC *20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □	IFC *20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □
ASSESSMENT	pt sat R well had no c/o pain R	pt sat R well minor in muscle tension low back R
PLAN	Cont to current doc K. Sgroi, PT	Cont to current doc K. Sgroi, PT

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

modality sheet

Name: [REDACTED]

Date: 11/30/10

Date: 12/19/10

SUBJECTIVE	PT c/o c/s/upper thoracic pain Pain = 3/10	PT stated she had N/A's since last RT No pain upper Thoracic
OBJECTIVE	Mod muscle Tension R ② c/s upper Thoracic	Minor & in muscle Tension to Back
NEURO RE-ED	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:
MASSAGE	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: FA	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: FA
TAPE/TE	KINESIO TAPE: ×1 □ ×2 □ ×3 □ LEUKO TAPE: ×1 □ ×2 □ ×3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET	KINESIO TAPE: ×1 □ ×2 □ ×3 □ LEUKO TAPE: ×1 □ ×2 □ ×3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET
IONTO	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ ×1 TREATMENT □ ×2 TREATMENTS □ ×24 MINUTES □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ ×1 TREATMENT □ ×2 TREATMENTS □ ×24 MINUTES □
US	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □
MANUAL	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:
ANODYNE	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:
MH/CP	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:
OTHER	IFC × 20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □	IFC × 20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □
ASSESSMENT	PT still c/o pain & to = 1/10 to RT	PT still had no c/o H&P RT
PLAN	Cont c current doc J. J. G. / RT	Cont c current doc J. J. G. / RT

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

modality sheet

Name:

Date: 10-26-10

Date: 11/9/10

SUBJECTIVE	Pt mother stated her leg felt like fello	Pt had no c/o fully like feeling in legs
OBJECTIVE	2 times this wk	No antalgic gait
NEURO RE-ED	TO: C/S & SHOULDERSE MID BACK LOW BACK HIP R UE L UE R LE L LE HAND WRIST ELBOW KNEE ANKLE FOOT TIME: 10 MIN 15 MIN 20 MIN 25 MIN OTHER:	TO: C/S & SHOULDERSE MID BACK LOW BACK HIP R UE L UE R LE L LE HAND WRIST ELBOW KNEE ANKLE FOOT TIME: 10 MIN 15 MIN 20 MIN 25 MIN OTHER:
MASSAGE	TO MUSCULATURE OF: C/S & SHOULDERSE MID BACK LOW BACK HIP R UE L UE R LE L LE HAND WRIST ELBOW KNEE ANKLE FOOT TIME: 20 MIN 25 MIN 30 MIN 40 MIN OTHER: FA	TO MUSCULATURE OF: C/S & SHOULDERSE MID BACK LOW BACK HIP R UE L UE R LE L LE HAND WRIST ELBOW KNEE ANKLE FOOT TIME: 20 MIN 25 MIN 30 MIN 40 MIN OTHER: FA
TAPE/TE	KINESIO TAPE: *10 *20 *30 LEUKO TAPE: *10 *20 *30 THERAPEUTIC EXERCISES: 15 MIN 30 MIN 45 MIN 60 MIN SEE FLOW SHEET	KINESIO TAPE: *10 *20 *30 LEUKO TAPE: *10 *20 *30 THERAPEUTIC EXERCISES: 15 MIN 30 MIN 45 MIN 60 MIN SEE FLOW SHEET
IONTO	TO: C/S & SHOULDERSE MID BACK LOW BACK HIP R UE L UE R LE L LE HAND WRIST ELBOW KNEE ANKLE FOOT DEXAMETHASONE ACETIC ACID *1 TREATMENT *2 TREATMENTS *24 MINUTES	TO: C/S & SHOULDERSE MID BACK LOW BACK HIP R UE L UE R LE L LE HAND WRIST ELBOW KNEE ANKLE FOOT DEXAMETHASONE ACETIC ACID *1 TREATMENT *2 TREATMENTS *24 MINUTES
US	TO: C/S & SHOULDERSE MID BACK LOW BACK HIP R UE L UE R LE L LE HAND WRIST ELBOW KNEE ANKLE FOOT TIME: 10 MIN 15 MIN 20 MIN 25 MIN W/CM2: .50 1.0 1.5 2.0 2.5	TO: C/S & SHOULDERSE MID BACK LOW BACK HIP R UE L UE R LE L LE HAND WRIST ELBOW KNEE ANKLE FOOT TIME: 10 MIN 15 MIN 20 MIN 25 MIN W/CM2: .50 1.0 1.5 2.0 2.5
MANUAL	TO: C/S & SHOULDERSE MID BACK LOW BACK HIP R UE L UE R LE L LE HAND WRIST ELBOW KNEE ANKLE FOOT TIME: 10 MIN 15 MIN 20 MIN 25 MIN OTHER:	TO: C/S & SHOULDERSE MID BACK LOW BACK HIP R UE L UE R LE L LE HAND WRIST ELBOW KNEE ANKLE FOOT TIME: 10 MIN 15 MIN 20 MIN 25 MIN OTHER:
ANODYNE	TO: C/S & SHOULDERSE MID BACK LOW BACK HIP R UE L UE R LE L LE HAND WRIST ELBOW KNEE ANKLE FOOT TIME: 30 MIN 45 MIN OTHER:	TO: C/S & SHOULDERSE MID BACK LOW BACK HIP R UE L UE R LE L LE HAND WRIST ELBOW KNEE ANKLE FOOT TIME: 30 MIN 45 MIN OTHER:
MUCCP	TO: C/S & SHOULDERSE MID BACK LOW BACK HIP R UE L UE R LE L LE HAND WRIST ELBOW KNEE ANKLE FOOT TIME: 20 MIN 25 MIN OTHER:	TO: C/S & SHOULDERSE MID BACK LOW BACK HIP R UE L UE R LE L LE HAND WRIST ELBOW KNEE ANKLE FOOT TIME: 20 MIN 25 MIN OTHER:
OTHER	IFC *20 MINUTES LASER THERAPEUTIC ACTIVITY OTHER:	IFC *20 MINUTES LASER THERAPEUTIC ACTIVITY OTHER:
ASSESSMENT	Pt told he well had no c/o pain	Pt told he well had no c/o pain
PLAN	Cont current rx	Cont current rx

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

modality sheet

Name:	10/12/10	Date: 10/21/10
SUBJECTIVE	SEE IF	Pt c/o low/mid each pain = 2/10
OBJECTIVE	SEE IF	No signs of AS in muscles Tension
NEURO RE-ED	TO: C/S & SHOULDERS MID BACK LOW BACK HIP R UED L UED R LEG L LEG HANDS WRIST ELBOW KNEED ANKLED FOOT TIME: 10 MIN 15 MIN 20 MIN 25 MIN OTHER:	TO: C/S & SHOULDERS MID BACK LOW BACK HIP R UED L UED R LEG L LEG HANDS WRIST ELBOW KNEED ANKLED FOOT TIME: 10 MIN 15 MIN 20 MIN 25 MIN OTHER:
MASSAGE	TO MUSCULATURE OF: C/S & SHOULDERS MID BACK LOW BACK HIP R UED L UED R LEG L LEG HANDS WRIST ELBOW KNEED ANKLED FOOT TIME: 20 MIN 25 MIN 30 MIN 40 MIN OTHER: FA	TO MUSCULATURE OF: C/S & SHOULDERS MID BACK LOW BACK HIP R UED L UED R LEG L LEG HANDS WRIST ELBOW KNEED ANKLED FOOT TIME: 20 MIN 25 MIN 30 MIN 40 MIN OTHER: FA
TAP/TE	KINESIO TAPE: *10 *20 *30 LEUKO TAPE: *10 *20 *30 THERAPEUTIC EXERCISES: 15 MIN 30 MIN 45 MIN 60 MIN SEE FLOW SHEET	KINESIO TAPE: *10 *20 *30 LEUKO TAPE: *10 *20 *30 THERAPEUTIC EXERCISES: 15 MIN 30 MIN 45 MIN 60 MIN SEE FLOW SHEET
IONTO	TO: C/S & SHOULDERS MID BACK LOW BACK HIP R UED L UED R LEG L LEG HANDS WRIST ELBOW KNEED ANKLED FOOT DEXAMETHASONE: ACETIC ACID: *1 TREATMENT *2 TREATMENTS *24 MINUTES	TO: C/S & SHOULDERS MID BACK LOW BACK HIP R UED L UED R LEG L LEG HANDS WRIST ELBOW KNEED ANKLED FOOT DEXAMETHASONE: ACETIC ACID: *1 TREATMENT *2 TREATMENTS *24 MINUTES
US	TO: C/S & SHOULDERS MID BACK LOW BACK HIP R UED L UED R LEG L LEG HANDS WRIST ELBOW KNEED ANKLED FOOT TIME: 10 MIN 15 MIN 20 MIN 25 MIN W/CN12: .50 1.00 1.50 2.00 2.50	TO: C/S & SHOULDERS MID BACK LOW BACK HIP R UED L UED R LEG L LEG HANDS WRIST ELBOW KNEED ANKLED FOOT TIME: 10 MIN 15 MIN 20 MIN 25 MIN W/CN12: .50 1.00 1.50 2.00 2.50
MANUAL	TO: C/S & SHOULDERS MID BACK LOW BACK HIP R UED L UED R LEG L LEG HANDS WRIST ELBOW KNEED ANKLED FOOT TIME: 10 MIN 15 MIN 20 MIN 25 MIN OTHER:	TO: C/S & SHOULDERS MID BACK LOW BACK HIP R UED L UED R LEG L LEG HANDS WRIST ELBOW KNEED ANKLED FOOT TIME: 10 MIN 15 MIN 20 MIN 25 MIN OTHER:
A/ODYNE	TO: C/S & SHOULDERS MID BACK LOW BACK HIP R UED L UED R LEG L LEG HANDS WRIST ELBOW KNEED ANKLED FOOT TIME: 30 MIN 45 MIN OTHER:	TO: C/S & SHOULDERS MID BACK LOW BACK HIP R UED L UED R LEG L LEG HANDS WRIST ELBOW KNEED ANKLED FOOT TIME: 30 MIN 45 MIN OTHER:
MIL/CP	TO: C/S & SHOULDERS MID BACK LOW BACK HIP R UED L UED R LEG L LEG HANDS WRIST ELBOW KNEED ANKLED FOOT TIME: 20 MIN 25 MIN OTHER:	TO: C/S & SHOULDERS MID BACK LOW BACK HIP R UED L UED R LEG L LEG HANDS WRIST ELBOW KNEED ANKLED FOOT TIME: 20 MIN 25 MIN OTHER:
OTHER	IFC *20 MINUTES LASER *15 min ST/LE/low back THERAPEUTIC ACTIVITY PROGRAM 2 OTHER:	IFC *20 MINUTES LASER THERAPEUTIC ACTIVITY OTHER:
ASSESSMENT	Pt still R well post Tensionless & leg 50% PR	Pt still R well c/o pain & to = 0 PR
PLAN	Cont & current pr FA prgr, pr	Cont & current pr FA prgr, pr

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

modality sheet

10/06/2010 WED 12:38 FAX 208 292 5441 LAKESIDE PEDIATRICS

001/005

REFERRAL REQUEST

Lakeside Pediatric & Adolescent Medicine, PLLC
980 W. Ironwood Drive, Suite 302
Coeur d' Alene, Idaho 83814
Phone (208) 292-5437 Fax (208) 292-5441

Date: 10/04/10

Referring Provider: Ronda L. Westcott, MD

Patient Name: [REDACTED] Age: [REDACTED] D.O.B: [REDACTED]

Parent/Guardian Name: Wayne Bryant

Home Phone #: (208) 762-5619

Insurance Policy Holder: Bryant, Wayne

Insurance Carrier: Blue Cross of Idaho & Medicaid

Insurance ID #: XMH970191763 & 0001643066 Group #: 10021090

Healthy Connection #: 806389000

Referred To: Joshua Tree Physical Therapy

Phone Number: 208-772-9774 Fax Number: 208-772-9564

DIAGNOSIS: 742.59 – *Spinal Cord Anomaly NEC*

Comments: Evaluation of leg fatigue and right sided intermittent tingling.

Requested Services: Evaluation, management, and physical therapy as needed.

Length of Referral: Effective 10/04/2010 – 10/04/2011

10/04/2010 4:13 PM

Patient Report By Patient Number **LAKE SIDE PEDIATRIC & ADOLESCENT MEDICINE**

Page 1

Selections:

Registered: 01/01/1990 - 10/04/2010
 Patients: [REDACTED]
 Accounts: 640
 Alerts: Excluded
 Notes: Excluded
 IDs: Excluded

808 [REDACTED]		Default Account: 640		Class: Y	
2417 E St James		SSN: [REDACTED]		Sex: Female	
Hayden, ID 83835		Chart #: [REDACTED]		DOB: [REDACTED]	
Email: [REDACTED]		Registered: 10/09/2007		Race / Ethnicity: C /	
Home: (208) 762-5619		First Visit: 10/09/2007		Lang: ENG	
Work: [REDACTED]		Last Visit: 09/20/2010		Marital: Single	
Emergency Contact:		Consent: Yes		Assigned: Westcott, MD, Ronda L.	
Bryant, Caren		Referral Src:		Referring:	
Pat Rel to Contact: Grandchild		Email: [REDACTED]			
Legal Guardian:		Home: (208) 651-6499			
Bryant, April		Work: [REDACTED]			
Pat Rel to Guardian: Child		Email: [REDACTED]			
		Home: (208) 762-4281			
		Work: (208) 772-2490			
		Mobile: (208) 651-5853			

Accounts:		Acct Finance Grp		Default		Status		Balance	
<u>Number</u>	<u>Guarantor</u>								
640	Bryant, Wayne		STNDRD		Y		Active		51.52

Ins. Policies:		Group		Claim Member IDs		Status		Subscriber		Relation to Sub		Accept Assign	
<u>Plan</u>													
1 BC01 - Blue Cross of Idaho					XMH970101703		Active		Bryant, Wayne		Child		Y
2 MCD01 - Medical					0001643066		Active		[REDACTED]		Self		Y

Extended Info:	
<u>Description</u>	<u>Value</u>
Dad's Nickname	Wayne Bryant
Mom's Nickname	April Bryant
Patient's Nickname	[REDACTED]

Total Patients: 1

002/005

10/06/2010 WED 12:38 FAX 208 292 5441 LAKE SIDE PEDIATRICS

10/06/2010 WED 12:39 FAX 208 292 5441 LAKESIDE PEDIATRICS

0003/005

Patient: 808 - [REDACTED]
DOB: [REDACTED]
SSN: [REDACTED]

Date: 10/04/2010 14:50
Provider: Westcott, MD, Ronda L.
Encounter: Acute Visit

ACTIVE PROBLEMS

- SPINAL CORD ANOMALY NEC - tethered cord s/p surgical repair at Arnold Chiari Institute. Had Lumboperitoneal shunt, but tied off 6/09. Syrx - down 30%. Due for shunt removal in spring 2010
- Urinary Calculus - Off hydrochlorothiazide (due to nephrocalcinosis on ultrasound 10/09), off Acetazolamide; Renal Ultrasound annually; Nephrology annually.

CHIEF COMPLAINT

The Chief Complaint is: Bladder issues and tingling in hands.

HISTORY OF PRESENT ILLNESS

[REDACTED] is a [REDACTED] year old female.

- Patient accompanied by mother.

Tingling in her right hand off and on (becoming more frequent), started 4 months ago. Not occurring on the left side. Sometimes has similar symptoms in feet, though again usually one sided.

Intermittent pain in both legs, usually exacerbated by activity - or will just be more fatigued than expected.

Still often has small amt of leaking urine after she voids - has tried change in position (sitting backward on potty), but no improvement in symptoms. Will often change underwear as they are wet. No burning with urination, no accidents. No bedwetting.

CURRENT MEDICATION

- Sodium Fluoride 2.2 (1 F) MG CHEW, , 90 days, 3 refills, Take one tab po qd

PAST MEDICAL/SURGICAL HISTORY

Reported History:

Medications: Taking medication HCTH, Fluoride, Vit D recommended.

Physical Trauma: Surgical incision.

Diagnosis History:

Nephrolithiasis.

Neurologic disorder Arnold Chiari malformation with tethered cord, s/p release. Spinal syrinx; LP shunt

ALLERGIES

- Latex Reaction: precaution

FAMILY HISTORY

Maternal cousin with Marfan Syndrome

REVIEW OF SYSTEMS

10/06/2010 WED 12:39 FAX 208 292 5441 LAKESIDE PEDIATRICS

0004/005

Patient: 808 - [REDACTED]
 DOB: [REDACTED]
 SSN: [REDACTED]

Date: 10/04/2010 14:50
 Provider: Westcott, MD, Ronda L.
 Encounter: Acute Visit

Systemic: No lethargy. No fever.
 Eyes: No purulent discharge from eyes and no bloodshot eyes.
 Otolaryngeal: No discharge from the ears and no nasal discharge or congestion.
 Pulmonary: No cough and no wheezing or dyspnea.
 Gastrointestinal: Normal appetite, no vomiting, and no diarrhea.
 Skin: No skin lesions.

PHYSICAL FINDINGS

• Vitals taken 10/04/2010 02:50 pm

wt. was 46-8	
Pulse Rate-Sitting	100 bpm
Respiration Rate	24 per min
Temp-Temporal	98.3 F
Weight	46 lbs 8 oz

General Appearance:

° Alert. ° In no acute distress.

Eyes:

General/bilateral:

External: ° Conjunctiva exhibited no abnormalities. ° No discharge from the conjunctiva.
 Optic Disc: ° Showed no papilledema.

Ears:

Right Ear:

Tympanic Membrane: • Examined and normal.

Left Ear:

Tympanic Membrane: • Examined and normal.

Nose:

General/bilateral:

Discharge: ° No nasal discharge seen.

Pharynx:

Oropharynx: ° Tonsils were not swollen. ° Tonsils were not erythematous. ° Tonsils showed no exudate. ° Not inflamed.

Lymph Nodes:

° Anterior cervical lymph nodes were not enlarged.

Lungs:

° Clear to auscultation.

Cardiovascular:

Heart Sounds: ° S1 normal. ° S2 normal.

Murmurs: ° No murmurs were heard.

Abdomen:

Palpation: ° No abdominal tenderness, was soft and non-distended.

Neurological:

Cranial Nerves: ° Normal.

Motor: ° Strength was normal.

Coordination / Cerebellum: ° No coordination/cerebellum abnormalities were noted.

Gait And Stance: ° Normal.

Reflexes: • Right knee jerk reflex unable to illicit. • Left knee jerk reflex normal.

Skin:

• Skin: no rash. Brisk capillary refill.

10/06/2010 WED 12:39 FAX 208 292 5441 LAKESIDE PEDIATRICS

005/005

Patient: 808 - [REDACTED]
 DOB: [REDACTED]
 SSN: [REDACTED]

Date: 10/04/2010 14:50
 Provider: Westcott, MD, Ronda L.
 Encounter: Acute Visit

TESTS**Urinalysis Was Performed:**

Urinalysis Results:	Value
Urine pH	6
Urine specific gravity	1025
Urine occult blood	1 +

Normal urine protein, negative for glucose, negative for bilirubin, negative for ketones, negative for nitrate, and negative for leukocyte esterase.

ASSESSMENT

- Primary diagnosis of post-void dribbling
- Peripheral neuropathy vs weakened muscles; vague history, normal neuro exam

PLAN

- SPINAL CORD ANOMALY NEC
 Referral: Physical Therapy

Patient with past normal urodynamic evaluation; symptoms of post void dribbling still seem due to external anatomy issues rather than inability to completely void. Monitor clinically - follow up with Urology in Seattle when there next.

Referred back to PT for further evaluation of weakened muscles vs mild peripheral neuropathy. Advised MVI daily and working to increase K in diet.

Annual follow up with Neurosurgery in Seattle.

Ronda L. Westcott, MD

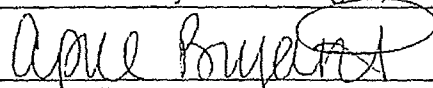
Electronically signed by: Ronda Westcott Date: 10/05/2010 17:14

Joshua Tree Physical Therapy**REGISTRATION FORM**

This information is necessary so that we may serve your needs

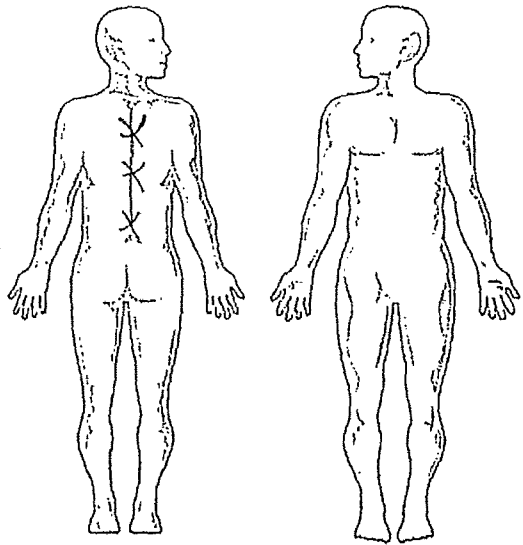
Information will not be released without your written consent

Today's date: 10/12/10				Referred By: Westcott		
PATIENT INFORMATION						
Patient's last name: [REDACTED]		First: [REDACTED]	Middle: [REDACTED]	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / S / Wid	
Birth date:	Age:	Sex:	Social Security #:	Home phone #:		
[REDACTED]	[REDACTED]	<input type="checkbox"/> M <input checked="" type="checkbox"/> F		651-5853		
Street address:						
2417 e. St James						
P.O. box:	City:	State:	ZIP Code:			
	Hayden	Id	83835			
Occupation:	Employer:	Employer phone#:				
Referring Physician:		Referring Physician Phone#:		Primary Physician:		
				Westcott		
Primary Physician Phone#:		Date of Injury:		Type of Injury:		
292-5437				Work Related <input type="checkbox"/> MVA <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/>		
How did your injury/ symptoms occur?			If MVA please provide the following:			
Surgical error in NY			Claim #: Insurance co.: Address:			
INSURANCE INFORMATION Same Blue Cross + ID m						
Subscriber's name:		Birth date:	Address (if different):		Home phone #:	
		1/23/78				
Subscriber's S.S.#:		Group #	Policy #		Co-pay	
[REDACTED]					\$	
Occupation:	Employer:	Employer address:			Employer phone #:	
Patient's relationship:		<input type="checkbox"/> Self	<input type="checkbox"/> Child	<input type="checkbox"/> Spouse	<input type="checkbox"/> Other	
Name of secondary insurance		Subscriber's name:		Group #:	Policy #:	

Patient's relationship to subscriber	<input type="checkbox"/> Self	<input checked="" type="checkbox"/> Child	<input type="checkbox"/> Spouse	<input type="checkbox"/> Other	
IN CASE OF EMERGENCY					
Name of local friend or relative (living at different residence)	Relationship:	Home phone #:	Work phone #:		
<p>Authorization for release of information: I authorize Kevin J. Sgroi, RPT, to release all medical information requested by my health insurance carrier, Medicare or any other third-party payers. I authorize Kevin J. Sgroi, RPT, to release all medical information to my referring physician and my primary (family) physician. I authorize Kevin J. Sgroi, RPT, to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Kevin J. Sgroi, RPT.</p> <p>Assignment of Benefits: I request that payment of authorized insurance benefits be made on my behalf Kevin J. Sgroi, RPT. I agree that these provisions will remain in effect until I provide written revocation to Kevin J. Sgroi, RPT. I further agree that should my insurance carrier and /or health plan administrator deem that my treatment, in full or part is not covered that I am responsible for all charges incurred as a result of treatment rendered by Kevin J. Sgroi, RPT and associates.</p>					
 Patient/Guardian signature			10/12/10 Date		

Referral Information : Initial Referral Received	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Length of service approved:	Follow up date:
--	------------------------------	-----------------------------	-----------------------------	-----------------

Joshua Tree Physical Therapy**CONFIDENTIAL INFORMATION**

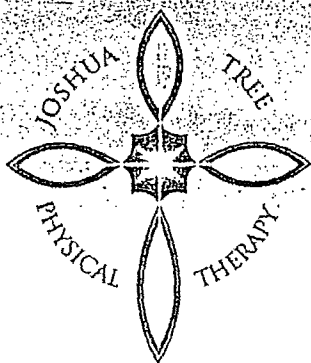
Do you have a history of the following?		
Have you ever received <i>massage therapy</i> ? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> accident <input type="checkbox"/> neck pain <input type="checkbox"/> whiplash <input type="checkbox"/> decreased range of motion <input type="checkbox"/> broken bones <input type="checkbox"/> sciatica <input type="checkbox"/> sprains <input type="checkbox"/> seizures <input type="checkbox"/> abdominal pain <input type="checkbox"/> nervous tension <input type="checkbox"/> arthritis, bursitis or gout <input type="checkbox"/> allergies to oils or perfumes <input type="checkbox"/> wear contacts <input type="checkbox"/> scoliosis	<input checked="" type="checkbox"/> surgery <input type="checkbox"/> fibromyalgia <input type="checkbox"/> carpal tunnel <input type="checkbox"/> mastectomy <input type="checkbox"/> breast augmentation <input type="checkbox"/> diabetes <input type="checkbox"/> varicose veins <input type="checkbox"/> high blood pressure <input type="checkbox"/> stroke <input type="checkbox"/> heart attack <input type="checkbox"/> cancer <input type="checkbox"/> colitis <input type="checkbox"/> HIV <input type="checkbox"/> other
Type of massage experienced: <input type="checkbox"/> Deep Tissue <input type="checkbox"/> Swedish <input type="checkbox"/> Other		
Are you currently taking medication? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Describe the medication you are taking below. 1. 2. 3. 4. 5.		
	Do you have any of the following today?	
	<input type="checkbox"/> sunburn <input type="checkbox"/> inflammation <input checked="" type="checkbox"/> severe pain <input type="checkbox"/> headache	<input type="checkbox"/> open cuts, burns, bruises <input type="checkbox"/> irritated skin rash <input type="checkbox"/> poison ivy <input type="checkbox"/> cold/flu
Are you pregnant? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Please Indicate with an(X), the areas you are feeling discomfort		
Have you consumed alcohol in the past 24 hours? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
What are your goals and expectations for this receiving physical therapy?		

Joshua Tree Physical Therapy

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have been provided a copy of and have read the Privacy Practice Notice. I understand my rights contained in the notice. By way of my signature, I consent Joshua Tree Physical Therapy to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

NAME [REDACTED]	DATE OF BIRTH [REDACTED]
SIGNATURE: <i>Amel B. [Signature]</i>	DATE: <i>12/30/13</i>



JOSHUA TREE PHYSICAL THERAPY

Initial Evaluation

Date: October 15, 2010.

Physician: Dr. Westcott

Re: [REDACTED]

Diagnosis: Mid/ Low back pain.

Dear Dr. Westcott:

Thank you for referring your patient to Joshua Tree Physical Therapy. Upon initial evaluation the following was determined.

History: The patient is a [REDACTED] female with complaints of mid and low back pain. At rest pain is rated at approximately 2/10 to 3/10 and increases to approximately 5/10 to 6/10 with activities of daily living. Patient does complain of radiating pain into the bilateral lower lower extremities. However, the patient does not complain of numbness and tingling into the bilateral lower extremities. Patient does complain of occasional headaches these are rated as moderate to severe.

PMH: Patient has been diagnosed with Chiari. Patient has undergone several surgical procedures secondary to this diagnosis. There has been a duraplasty patch surgically implanted at the base of the child's skull. She also has a lumbar shunt to enhance the flow of cerebral spinal fluid. Patient also had surgery for removal of vertebrae C1 and L3 through L5. Patient also has been diagnosed with hypercalcemic production and is taking medication HCTC for this condition.

Objective:

Active Range of Motion

Loss of Movement:

Lumbar flexion:	Moderate with severe complaints of low back pain
Lumbar extension:	Minimal with complaints of low back pain.
Lateral flexion left:	Minimal with complaints of tightness and pulling
Lateral flexion right:	Minimal with complaints of tightness and pulling
Rotation right:	None without complaints of pain
Rotation left:	None without complaints of pain

Manual Muscle Test:

	Left	Right.
Quadriceps:	4/5	4+/5
Hamstrings:	4/5	4+/5
Ankle plantarflexion:	4/5	4+/5
Dorsiflexion:	4/5	4+/5
Dorsi flexion great toe:	4/5	4+/5

Objective:

AROM.

	Left		Right.
Cervical flexion:		80 % of normal	
Cervical extension:		90 % of normal.	
Lateral flexion:	80 %		80%.
Rotation:	90 %		90%.
Shoulder AROM:	180°		180 °

8475 NORTH GOVERNMENT WAY, HAYDEN, IDAHO 83815

PHONE: 208-772-9774 FAX: 208-772-9564

(flexion)

Observation: Patient is able to perform bilateral heel raises equally however, when performing heel raises unilaterally the patient had more difficulty raising the heel on right when compared to left.

Reflexes: Left Achilles and patella reflexes are within normal limits. Right Achilles and patella reflexes are moderately diminished.

Palpation: There are noted numerous trigger points and tonic muscle spasms throughout the cervical, thoracic, and lumbar paraspinals.

Treatment Program: The patient will receive education on proper body mechanics and posture. Treatment and modalities will include, anodyne light treatment, medical massage, neuromuscular reeducation, therapeutic laser, therapeutic exercises, and home exercise program.

Assessment:

Problem List:

- Complaints of pain at rest.
- Complaints of pain with activities of daily living.
- Tonic muscle spasms noted throughout all paraspinals.
- Decreased active range of motion cervical spine and lumbar spine.
- Complaints of constant headaches

Short-Term Goals: Four weeks

- Decrease complaints of pain at rest by 50%.
- Decrease tonic muscle spasms by 50%.
- Increase active range of motion cervical and lumbar spine to WNL.


Long-term goals: Eight weeks.

- Decrease complaints of pain at rest to 0/10.
- Patient to perform activities daily living without complaints of pain.
- Decrease tonic muscle spasms by 90%.
- Patient to be independent with supervision in home exercise program.

Plan of Care: The patient will receive the above treatment program two to three times a week for up to eight weeks. The treatment program will be upgraded and modified as per physician's recommendations and as patient tolerates to achieve the above goals.

Once, again thank you for referring your patient to Joshua Tree Physical Therapy. If you have any questions or recommendations about your patient's care please contact me at your earliest convenience.

Respectfully,


Kevin J. Sgroi, RPT

07/17/2012 13:17 FAX

002

Name: 10/12/10
Date:Date: 10/21/10

SUBJECTIVE	SEE IF	Pt c/o red/mul each pair = $\frac{2}{10}$
OBJECTIVE	SEE IF	No signs of 45° muscle Tension
NEURO REFED	TO: C/S & SHOULDERS, MID BACK, LOW BACK, HIP, R UE, L UE, R LE, L LE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN OTHER:	TO: C/S & SHOULDERS, MID BACK, LOW BACK, HIP, R UE, L UE, R LE, L LE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN OTHER:
MASSAGE	TO MUSCULATURE OF: C/S & SHOULDERS, MID BACK, LOW BACK, HIP, R UE, L UE, R LE, L LE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 20 MIN, 25 MIN, 30 MIN, 40 MIN OTHER: FA	TO MUSCULATURE OF: C/S & SHOULDERS, MID BACK, LOW BACK, HIP, R UE, L UE, R LE, L LE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 20 MIN, 25 MIN, 30 MIN, 40 MIN OTHER: FA
TAPE/TE	KINESIO TAPE: *10 *20 *30 LEUKO TAPE: *10 *20 *30 THERAPEUTIC EXERCISES: 15 MIN, 30 MIN, 45 MIN, 60 MIN SEE FLOW SHEET	KINESIO TAPE: *10 *20 *30 LEUKO TAPE: *10 *20 *30 THERAPEUTIC EXERCISES: 15 MIN, 30 MIN, 45 MIN, 60 MIN SEE FLOW SHEET
IONTO	TO: C/S & SHOULDERS, MID BACK, LOW BACK, HIP, R UE, L UE, R LE, L LE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT Dexamethasone *1 TREATMENT *2 TREATMENTS *24 MINUTES ACETIC ACID	TO: C/S & SHOULDERS, MID BACK, LOW BACK, HIP, R UE, L UE, R LE, L LE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT Dexamethasone *1 TREATMENT *2 TREATMENTS *24 MINUTES ACETIC ACID
US	TO: C/S & SHOULDERS, MID BACK, LOW BACK, HIP, R UE, L UE, R LE, L LE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN W/CN12: .50 1.00 1.50 2.00 2.50	TO: C/S & SHOULDERS, MID BACK, LOW BACK, HIP, R UE, L UE, R LE, L LE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN W/CN12: .50 1.00 1.50 2.00 2.50
MANUAL	TO: C/S & SHOULDERS, MID BACK, LOW BACK, HIP, R UE, L UE, R LE, L LE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN OTHER:	TO: C/S & SHOULDERS, MID BACK, LOW BACK, HIP, R UE, L UE, R LE, L LE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN OTHER:
ANODYNE	TO: C/S & SHOULDERS, MID BACK, LOW BACK, HIP, R UE, L UE, R LE, L LE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 30 MIN, 45 MIN OTHER:	TO: C/S & SHOULDERS, MID BACK, LOW BACK, HIP, R UE, L UE, R LE, L LE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 30 MIN, 45 MIN OTHER:
MIMP	TO: C/S & SHOULDERS, MID BACK, LOW BACK, HIP, R UE, L UE, R LE, L LE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 20 MIN, 25 MIN OTHER:	TO: C/S & SHOULDERS, MID BACK, LOW BACK, HIP, R UE, L UE, R LE, L LE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 20 MIN, 25 MIN OTHER:
OTHER	IFC *20 MINUTES LASER *15 min S/H/L/Looked THERAPEUTIC ACTIVITY PROGRAM OTHER:	IFC *20 MINUTES LASER THERAPEUTIC ACTIVITY OTHER:
ASSESSMENT	Pt still in well point Tenderness & leg 50% PR	Pt still in well c/o pain & to = $\frac{9}{10}$ PR
PLAN	Cont to currit A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	Cont to currit A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. 56

07/17/2016 13:18 FAX

0003

Subjective

Objective

NEURO
Re-Ed

Massage

Tape/TE

Isoto

US

Manual

Anodyne

MHCT

Assessment

Plan

NAME: [REDACTED]	SSN: [REDACTED]
DATE: 07/16/16	DATE: [REDACTED]
SEE IE	
SEE IE	
To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> RUE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input checked="" type="checkbox"/> 25 min <input type="checkbox"/> OTHER:	To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> OTHER:
To Musculature of: C/SO Shoulders <input checked="" type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Hip <input type="checkbox"/> Low Back <input type="checkbox"/> RUE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input checked="" type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To Musculature of: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> RUE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:
Kinesio tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> Leuko tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>	Kinesio tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> Leuko tape: x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>
To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x2 treatments <input type="checkbox"/> x24 minutes <input type="checkbox"/>	To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x2 treatments <input type="checkbox"/> x24 minutes <input type="checkbox"/>
To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> RUE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> W/CM2: .50 1.00 1.50 2.00 2.50	To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> W/CM2: .50 1.00 1.50 2.00 2.50
To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> RUE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:
To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> RUE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:	To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:
To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:	To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LE <input type="checkbox"/> L LE <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:
Re measure for symmetry ③ F Body	
Held on by [Signature]	

Kevin J. Sgrol, RPT

Kevin J. Sgrol, RPT

07/17/2012 13:19 FAX

004

NAME:

DATE:

SSN:

DATE:

Subjective

Objective

NEURO
Re-Ed

Massage

Tape/IE

Lotion

US

Manual

Anodyne

MF/CP

Assessment

Plan

pt Mom stated she
had no d/s since last
Tx

No tight muscles Tighten
to paraspinal

To: C/S ☐ Shoulders ☐ Mid Back ☐ Low Back ☐ Hip ☐ R UE ☐
L UE ☐ R LE ☐ L LE ☐ Hand ☐ Elbow ☐ Wrist ☐ Knee ☐
Ankle ☐ TIME: 10 min ☐ 15 min ☐ 20 min ☐ 25 min ☐
OTHER:

To Musculature of: C/S ☐ Shoulders ☐ Mid Back ☐ Hip ☐
Low Back ☐ R UE ☐ L UE ☐ R LE ☐ L LE ☐ Hand ☐
Wrist ☐ Elbow ☐ Knee ☐ Ankle ☐
TIME: 20 min ☐ 25 min ☐ 30 min ☐ *88*
OTHER:

Kinesio tape: x1 ☐ x2 ☐ x3 ☐
Leuko tape: x1 ☐ x2 ☐ x3 ☐
THERAPEUTIC EXERCISES: 15 min ☐ 30 min ☐ 45 min ☐
See Flow Sheet 60 min ☐

To: C/S ☐ Shoulders ☐ Mid Back ☐ Low Back ☐ Hip ☐
R UE ☐ L UE ☐ R LE ☐ L LE ☐ Hand ☐ Elbow ☐ Wrist ☐ Knee ☐
Ankle ☐ Dexamethasone ☐ Acetic Acid ☐
x1 treatment ☐ x2 treatments ☐ x24 minutes ☐

To: C/S ☐ Shoulders ☐ Mid Back ☐ Low Back ☐ Hip ☐ R UE ☐
L UE ☐ R LE ☐ L LE ☐ Hand ☐ Elbow ☐ Wrist ☐ Knee ☐
Ankle ☐ TIME: 10 min ☐ 15 min ☐ 20 min ☐ 25 min ☐
W/CM2: .50 ☐ 1.00 ☐ 1.50 ☐ 2.00 ☐ 2.50 ☐

To: C/S ☐ Shoulders ☐ Mid Back ☐ Low Back ☐ Hip ☐ R UE ☐
L UE ☐ R LE ☐ L LE ☐ Hand ☐ Elbow ☐ Wrist ☐ Knee ☐ Ankle ☐
TIME: 15 min ☐ 20 min ☐ 25 min ☐ 30 min ☐
OTHER:

To: C/S ☐ Shoulders ☐ Mid Back ☐ Low Back ☐ Hip ☐ R UE ☐
L UE ☐ R LE ☐ L LE ☐ Hand ☐ Elbow ☐ Wrist ☐ Knee ☐ Ankle ☐
TIME: 30 min ☐ 45 min ☐
OTHER:

To: C/S ☐ Shoulders ☐ Mid Back ☐ Low Back ☐ Hip ☐
R UE ☐ L UE ☐ R LE ☐ L LE ☐ Hand ☐ Elbow ☐ Wrist ☐
Knee ☐ Ankle ☐ TIME: 20 min ☐
OTHER:

pt Mom will have
no c/o of pain since
last Tx

Cont'd current doc
St. J. Sgroi, RPT

To: C/S ☐ Shoulders ☐ Mid Back ☐ Low Back ☐ Hip ☐ R UE ☐
L UE ☐ R LE ☐ L LE ☐ Hand ☐ Elbow ☐ Wrist ☐ Knee ☐
Ankle ☐ TIME: 10 min ☐ 15 min ☐ 20 min ☐ 25 min ☐
OTHER:

To Musculature of: C/S ☐ Shoulders ☐ Mid Back ☐ Hip ☐
Low Back ☐ R UE ☐ L UE ☐ R LE ☐ L LE ☐ Hand ☐
Wrist ☐ Elbow ☐ Knee ☐ Ankle ☐
TIME: 20 min ☐ 25 min ☐ 30 min ☐
OTHER:

Kinesio tape: x1 ☐ x2 ☐ x3 ☐
Leuko tape: x1 ☐ x2 ☐ x3 ☐
THERAPEUTIC EXERCISES: 15 min ☐ 30 min ☐ 45 min ☐
See Flow Sheet 60 min ☐

To: C/S ☐ Shoulders ☐ Mid Back ☐ Low Back ☐ Hip ☐
R UE ☐ L UE ☐ R LE ☐ L LE ☐ Hand ☐ Elbow ☐ Wrist ☐ Kn
Ankle ☐ Dexamethasone ☐ Acetic Acid ☐
x1 treatment ☐ x2 treatments ☐ x24 minutes ☐

To: C/S ☐ Shoulders ☐ Mid Back ☐ Low Back ☐ Hip ☐ R U
L UE ☐ R LE ☐ L LE ☐ Hand ☐ Elbow ☐ Wrist ☐ Knee ☐
Ankle ☐ TIME: 10 min ☐ 15 min ☐ 20 min ☐ 25 min ☐
W/CM2: .50 ☐ 1.00 ☐ 1.50 ☐ 2.00 ☐ 2.50 ☐

To: C/S ☐ Shoulders ☐ Mid Back ☐ Low Back ☐ Hip ☐ R U
L UE ☐ R LE ☐ L LE ☐ Hand ☐ Elbow ☐ Wrist ☐ Knee ☐ Ank
TIME: 15 min ☐ 20 min ☐ 25 min ☐ 30 min ☐
OTHER:

To: C/S ☐ Shoulders ☐ Mid Back ☐ Low Back ☐ Hip ☐ R U
L UE ☐ R LE ☐ L LE ☐ Hand ☐ Elbow ☐ Wrist ☐ Knee ☐ Ank
TIME: 30 min ☐ 45 min ☐
OTHER:

To: C/S ☐ Shoulders ☐ Mid Back ☐ Low Back ☐ Hip ☐
R UE ☐ L UE ☐ R LE ☐ L LE ☐ Hand ☐ Elbow ☐ Wrist
Knee ☐ Ankle ☐ TIME: 20 min ☐
OTHER:

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

58

07/17/2012 13:20 FAX

0000

NAME: [REDACTED]
DATE: 6/4/09 ✓SSN: [REDACTED]
DATE: 6-9-09 ✓

Subjective

Pt Dad stated [REDACTED]
has not had a H/A
since last RPt Mom stated [REDACTED]
has had 7 in H/A past
few days.

Objective

Pt not as fatigued
todayPt had minor 7 in
muscle tension to para-
spinalNEURO
Re-EdTo: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒ R UE ☒
L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒ Knee ☒
Ankle ☒ TIME: 10 min ☐ 15 min ☐ 20 min ☐ 25 min ☐
OTHER:To: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒ R UE ☒
L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒ Knee ☒
Ankle ☒ TIME: 10 min ☐ 15 min ☐ 20 min ☐ 25 m ☐
OTHER:

Massage

To Musculature of: C/S ☒ Shoulders ☒ Mid Back ☒ Hip ☒
Low Back ☒ R UE ☒ L UE ☒ R LE ☒ L LE ☒ Hand ☒
Wrist ☒ Elbow ☒ Knee ☒ Ankle ☒
TIME: 20 min ☐ 25 min ☐ 30 min ☐
OTHER:To Musculature of: C/S ☒ Shoulders ☒ Mid Back ☒ Hip ☒
Low Back ☒ R UE ☒ L UE ☒ R LE ☒ L LE ☒ Hand ☒
Wrist ☒ Elbow ☒ Knee ☒ Ankle ☒
TIME: 20 min ☐ 25 min ☐ 30 min ☐
OTHER:

Tape/TE

Kinesio tape: x1 ☐ x2 ☐ x3 ☐
Louko tape: x1 ☐ x2 ☐ x3 ☐
THERAPEUTIC EXERCISES: 15 min ☐ 30 min ☐ 45 min ☐
See Flow Sheet 60 min ☐Kinesio tape: x1 ☐ x2 ☐ x3 ☐
Louko tape: x1 ☐ x2 ☐ x3 ☐
THERAPEUTIC EXERCISES: 15 min ☐ 30 min ☐ 45 min ☐
See Flow Sheet 60 min ☐

Iontophoresis

To: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒
R UE ☒ L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒ Knee ☒
Ankle ☒ Dexamethasone ☐ Acetic Acid ☐
x1 treatment ☐ x2 treatments ☐ x24 minutes ☐To: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒
R UE ☒ L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒ Knee ☒
Ankle ☒ Dexamethasone ☐ Acetic Acid ☐
x1 treatment ☐ x2 treatments ☐ x24 minutes ☐

US

To: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒ R UE ☒
L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒ Knee ☒
Ankle ☒ TIME: 10 min ☐ 15 min ☐ 20 min ☐ 25 min ☐
W/CM2: .50 1.00 1.50 2.00 2.50To: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒ R UE ☒
L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒ Knee ☒
Ankle ☒ TIME: 10 min ☐ 15 min ☐ 20 min ☐ 25 min ☐
W/CM2: .50 1.00 1.50 2.00 2.50

Manual

To: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒ R UE ☒
L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒ Knee ☒ Ankle ☒
TIME: 15 min ☐ 20 min ☐ 25 min ☐ 30 min ☐
OTHER:To: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒ R UE ☒
L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒ Knee ☒ Ankle ☒
TIME: 15 min ☐ 20 min ☐ 25 min ☐ 30 min ☐
OTHER:

Anodyne

To: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒ R UE ☒
L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒ Knee ☒ Ankle ☒
TIME: 30 min ☐ 45 min ☐
OTHER:To: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒ R UE ☒
L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒ Knee ☒ Ankle ☒
TIME: 30 min ☐ 45 min ☐
OTHER:

MH/CP

To: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒
R UE ☒ L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒
Knee ☒ Ankle ☒ TIME: 20 min ☐
OTHER:To: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒
R UE ☒ L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒
Knee ☒ Ankle ☒ TIME: 20 min ☐
OTHER:

Assessment

Pt still R well had
no C/O pain to RPt still R well had
no C/O H/A to R

Plan

Cont to current [REDACTED]
[Signature]Cont to current [REDACTED]
[Signature]

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

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07/17/2012 13:20 FAX

10008

	NAME DATE: 5/14/09	SSN: DATE: 6/2/09
Subjective	PT mom stated [redacted] was playing for ~ 1 Hr. Then no severe HA	PT's dad stated he's w/A here and since NOT having PT
Objective	No significant muscle tension to back	PT very fatigued to golf
NEURO Re-Ed	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 10 min □ 15 min □ 20 min □ 25 min □ OTHER:	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 10 min □ 15 min □ 20 min □ 25 min □ OTHER:
Massage	To Musculature of: C/S□ Shoulders□ Mid Back□ Hip□ Low Back□ R UE□ L UE□ R LE□ L LE□ Hand□ Wrist□ Elbow□ Knee□ Ankle□ TIME: 20 min □ 25 min □ 30 min □ OTHER: CAR	To Musculature of: C/S□ Shoulders□ Mid Back□ Hip□ Low Back□ R UE□ L UE□ R LE□ L LE□ Hand□ Wrist□ Elbow□ Knee□ Ankle□ TIME: 20 min □ 25 min □ 30 min □ OTHER: ITB + PIRIFORMIS
Tape/TE	Kinesio tape: x1□ x2□ x3□ Leuko tape: x1□ x2□ x3□ THERAPEUTIC EXERCISES: 15 min□ 30 min□ 45 min□ Sec Flow Sheet 60 min□	Kinesio tape: x1□ x2□ x3□ Leuko tape: x1□ x2□ x3□ THERAPEUTIC EXERCISES: 15 min□ 30 min□ 45 min□ Sec Flow Sheet 60 min□
Ionto	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ Dexamethasone□ Acetic Acid□ x1 treatment□ x2 treatments□ x24 minutes□	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ Dexamethasone□ Acetic Acid□ x1 treatment□ x2 treatments□ x24 minutes□
US	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 10 min □ 15 min □ 20 min □ 25 min □ W/CM2: .5□ 1.0□ 1.5□ 2.0□ 2.5□	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 10 min □ 15 min □ 20 min □ 25 min □ W/CM2: .5□ 1.0□ 1.5□ 2.0□ 2.5□
Manual	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 15 min □ 20 min □ 25 min □ 30 min □ OTHER:	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 15 min □ 20 min □ 25 min □ 30 min □ OTHER:
Anodyne	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 30 min □ 45 min □ OTHER:	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 30 min □ 45 min □ OTHER:
MHC/P	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 20 min □ OTHER:	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UE□ L UE□ R LE□ L LE□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 20 min □ OTHER:
Assessment	PT still well had no C/O HA to R	PT still well had no C/O HA to R
Plan	Cont to current PT KJ Sgroi, RPT	Cont to current PT KJ Sgroi, RPT

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

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07/17/2012 13:21 FAX

007

	NAME DATE: 5/7/09	SSN DATE: 5/12/09
Subjective	Pt stated she was Tired Today	Pt mother stated [redacted] has not had any HA since last
Objective	Pt To have Photo Taken Today	No + - muscle tension to back
NEURO Re-Ed	To: C/SO Shoulders Mid Back Low Back Hip R UE L UE R LE L LE Hand Elbow Wrist Knee Ankle TIME: 10 min 15 min 20 min 25 min OTHER:	To: C/SO Shoulders Mid Back Low Back Hip R L UE R LE L LE Hand Elbow Wrist K Ankle TIME: 10 min 15 min 20 min 25 OTHER:
Message	To Musculature of: C/SO Shoulders Mid Back Hip Low Back R UE L UE R LE L LE Hand Wrist Elbow Knee Ankle TIME: 20 min 25 min 30 min OTHER:	To Musculature of: C/SO Shoulders Mid Back Hip Low Back R UE L UE R LE L LE Han Wrist Elbow Knee Ankle TIME: 20 min 25 min 30 min OTHER: Glutes, ITB, Piriformis
Tape/TE	Kinesio tape: x1 x2 x3 Leuko tape: x1 x2 x3 THERAPEUTIC EXERCISES: 15 min 30 min 45 min See Flow Sheet 60 min	Kinesio tape: x1 x2 x3 Leuko tape: x1 x2 x3 THERAPEUTIC EXERCISES: 15 min 30 min 45 min See Flow Sheet 60 min
Ionio	To: C/SO Shoulders Mid Back Low Back Hip R UE L UE R LE L LE Hand Elbow Wrist Knee Ankle Dexamethasone Acetic Acid x1 treatment x2 treatments x24 minutes	To: C/SO Shoulders Mid Back Low Back Hip R UE L UE R LE L LE Hand Elbow Wrist Ankle Dexamethasone Acetic Acid x1 treatment x2 treatments x24 minutes
US	To: C/SO Shoulders Mid Back Low Back Hip R UE L UE R LE L LE Hand Elbow Wrist Knee Ankle TIME: 10 min 15 min 20 min 25 min W/CM2: .50 1.00 1.50 2.00 2.50	To: C/SO Shoulders Mid Back Low Back Hip L UE R LE L LE Hand Elbow Wrist Kne Ankle TIME: 10 min 15 min 20 min 25 W/CM2: .50 1.00 1.50 2.00 2.50
Mammal	To: C/SO Shoulders Mid Back Low Back Hip R UE L UE R LE L LE Hand Elbow Wrist Knee Ankle TIME: 15 min 20 min 25 min 30 min OTHER:	To: C/SO Shoulders Mid Back Low Back Hip L UE R LE L LE Hand Elbow Wrist Knee TIME: 15 min 20 min 25 min 30 min OTHER:
Anodyne	To: C/SO Shoulders Mid Back Low Back Hip R UE L UE R LE L LE Hand Elbow Wrist Knee Ankle TIME: 30 min 45 min OTHER:	To: C/SO Shoulders Mid Back Low Back Hip L UE R LE L LE Hand Elbow Wrist Knee TIME: 30 min 45 min OTHER:
MFCP	To: C/SO Shoulders Mid Back Low Back Hip R UE L UE R LE L LE Hand Elbow Wrist Knee Ankle TIME: 20 min OTHER:	To: C/SO Shoulders Mid Back Low Back Hip R UE L UE R LE L LE Hand Elbow Knee Ankle TIME: 20 min OTHER:
Assessment	Pt not in much better tired P.R.	Pt not in much no C/O pain P.R.
Plan	Cont'd current P.O. [Signature]	Cont'd current P.O. [Signature]

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

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07/17/2012 13:22 FAX

008

NAME	DATE	SS	DATE
[REDACTED]	5/5/09	[REDACTED]	5/5/09
Subjective	Pt. Mom started her Spent in driving to much est		Pt. stated [REDACTED] is going to have her Spent removed next week
Objective	No [REDACTED] [REDACTED] to low back [REDACTED]		No signif [REDACTED] noted
NEURO Re-Ed	To: C/SO Shoulders Mid Back Low Back Hip R UEO L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle TIME: 10 min 15 min 20 min 25 min OTHER:		To: C/SO Shoulders Mid Back Low Back Hip L UEO R LEO L LEO Hand Elbow Wrist K Ankle TIME: 10 min 15 min 20 min OTHER:
Massage	To Musculature of: C/SO Shoulders Mid Back Hip Low Back R UEO L UEO R LEO L LEO Hand Wrist Elbow Knee Ankle TIME: 20 min 25 min 30 min OTHER: ITB & Perforans		To Musculature of: C/SO Shoulders Mid Back H Low Back R UEO L UEO R LEO L LEO H Wrist Elbow Knee Ankle TIME: 20 min 25 min 30 min OTHER: ITB & Blutes
Tape/TE	Kinesio tape: x1 x2 x3 Louko tape: x1 x2 x3 THERAPEUTIC EXERCISES: 15 min 30 min 45 min See Flow Sheet 60 min		Kinesio tape: x1 x2 x3 Leuko tape: x1 x2 x3 THERAPEUTIC EXERCISES: 15 min 30 min 45 See Flow Sheet 60 min
Ionid	To: C/SO Shoulders Mid Back Low Back Hip R UEO L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle Dexamethasone Acetic Acid x1 treatment x2 treatments x24 minutes		To: C/SO Shoulders Mid Back Low Back I R UEO L UEO R LEO L LEO Hand Elbow Wrist Ankle Dexamethasone Acetic Acid x1 treatment x2 treatments x24 minutes
US	To: C/SO Shoulders Mid Back Low Back Hip R UEO L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle TIME: 10 min 15 min 20 min 25 min W/CM2: .50 1.00 1.50 2.00 2.50		To: C/SO Shoulders Mid Back Low Back Hip L UEO R LEO L LEO Hand Elbow Wrist K Ankle TIME: 10 min 15 min 20 min W/CM2: .50 1.00 1.50 2.00 2.50
Manual	To: C/SO Shoulders Mid Back Low Back Hip R UEO L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle TIME: 15 min 20 min 25 min 30 min OTHER:		To: C/SO Shoulders Mid Back Low Back Hip L UEO R LEO L LEO Hand Elbow Wrist Knee TIME: 15 min 20 min 25 min 30 min OTHER:
Anodyne	To: C/SO Shoulders Mid Back Low Back Hip R UEO L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle TIME: 30 min 45 min OTHER:		To: C/SO Shoulders Mid Back Low Back Hip L UEO R LEO L LEO Hand Elbow Wrist Knee TIME: 30 min 45 min OTHER:
MUSCUP	To: C/SO Shoulders Mid Back Low Back Hip R UEO L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle TIME: 20 min OTHER:		To: C/SO Shoulders Mid Back Low Back H R UEO L UEO R LEO L LEO Hand Elbow Knee Ankle TIME: 20 min OTHER:
Assessment	Pt. sat R in well bed no C/O pain p R		Pt. sat R in well bed no C/O H/A p R
Plan	Cont to current [REDACTED] [REDACTED]		Cont to current [REDACTED] [REDACTED]
	Kevin J. Sgroi, RPT		Kevin J. Sgroi, RPT

07/17/2012 13:22 FAX

0009

	NAME DATE: 4/23/09	SSN: DATE: 4/28/09 ✓
Subjective	Pl Mom stated [redacted] has been sick since few wks	Pl stated she does not have as many wks
Objective	No signif + muscle tension to back	No + muscle tension to back
NEURO Re-Ed	To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> RUEO <input type="checkbox"/> L UE <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> OTHER:	To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> RUEO <input type="checkbox"/> L UE <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> OTHER:
Massage	To Musculature of: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Hip <input type="checkbox"/> Low Back <input type="checkbox"/> RUEO <input type="checkbox"/> L UE <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER: Glutes, ITB, Piriformis	To Musculature of: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Hip <input type="checkbox"/> Low Back <input type="checkbox"/> RUEO <input type="checkbox"/> L UE <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:
Tape/TE	Kinesio tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> Loulco tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>	Kinesio tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> Loulco tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>
Formo	To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x 2 treatments <input type="checkbox"/> x 24 minutes <input type="checkbox"/>	To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> K <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x 2 treatments <input type="checkbox"/> x 24 minutes <input type="checkbox"/>
US	To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> RUEO <input type="checkbox"/> L UE <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> W/CM2: .50 <input type="checkbox"/> 1.00 <input type="checkbox"/> 1.50 <input type="checkbox"/> 2.00 <input type="checkbox"/> 2.50 <input type="checkbox"/>	To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R L <input type="checkbox"/> L UE <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> W/CM2: .50 <input type="checkbox"/> 1.00 <input type="checkbox"/> 1.50 <input type="checkbox"/> 2.00 <input type="checkbox"/> 2.50 <input type="checkbox"/>
Manual	To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> RUEO <input type="checkbox"/> L UE <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R L <input type="checkbox"/> L UE <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> An <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:
Anodyne	To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> RUEO <input type="checkbox"/> L UE <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:	To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> RU <input type="checkbox"/> L UE <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> An <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:
MF/UCP	To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:	To: C/SO Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UE <input type="checkbox"/> L UE <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wri <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:
Assessment	Pl told R well had no C/O pain to R	Pl told R well had no C/O pain to R
Plan	Cont'd current [signature]	Cont'd current [signature]

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

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07/17/2012 13:23 FAX

010

NAME:
DATE:

3/24/09

SSN:
DATE:

3/26/09

Subjective

Rt mother stated [redacted] did not have HA for 4-5 days

Rt Lee Mon no HA since last visit

Objective

No muscle tension
C/S / [redacted]

Minor muscle tension to back

NEURO
Re-Ed

To: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒ R UE ☒
L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒ Knee ☒
Ankle ☒ TIME: 10 min ☒ 15 min ☒ 20 min ☒ 25 min ☒
OTHER:

To: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒ R UE ☒
L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒ Knee ☒
Ankle ☒ TIME: 10 min ☒ 15 min ☒ 20 min ☒ 25 min ☒
OTHER:

Massage

To Musculature of: C/S ☒ Shoulders ☒ Mid Back ☒ Hip ☒
Low Back ☒ R UE ☒ L UE ☒ R LE ☒ L LE ☒ Hand ☒
Wrist ☒ Elbow ☒ Knee ☒ Ankle ☒
TIME: 20 min ☒ 25 min ☒ 30 min ☒
OTHER:

To Musculature of: C/S ☒ Shoulders ☒ Mid Back ☒ Hip ☒
Low Back ☒ R UE ☒ L UE ☒ R LE ☒ L LE ☒ Hand ☒
Wrist ☒ Elbow ☒ Knee ☒ Ankle ☒
TIME: 20 min ☒ 25 min ☒ 30 min ☒
OTHER:

Tape/TE

Kinesio tape: x1 ☒ x2 ☒ x3 ☒
Leuko tape: x1 ☒ x2 ☒ x3 ☒
THERAPEUTIC EXERCISES: 15 min ☒ 30 min ☒ 45 min ☒
See Flow Sheet 60 min ☒

Kinesio tape: x1 ☒ x2 ☒ x3 ☒
Leuko tape: x1 ☒ x2 ☒ x3 ☒
THERAPEUTIC EXERCISES: 15 min ☒ 30 min ☒ 45 min ☒
See Flow Sheet 60 min ☒

Iontoph

To: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒
R UE ☒ L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒ Knee ☒
Ankle ☒ Dexamethasone ☒ Acetic Acid ☒
x1 treatment ☒ x2 treatments ☒ x24 minutes ☒

To: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒
R UE ☒ L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒ Knee ☒
Ankle ☒ Dexamethasone ☒ Acetic Acid ☒
x1 treatment ☒ x2 treatments ☒ x24 minutes ☒

US

To: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒ R UE ☒
L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒ Knee ☒
Ankle ☒ TIME: 10 min ☒ 15 min ☒ 20 min ☒ 25 min ☒
W/CM2: 50 ☒ 1.00 ☒ 1.50 ☒ 2.00 ☒ 2.50 ☒

To: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒ R UE ☒
L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒ Knee ☒
Ankle ☒ TIME: 10 min ☒ 15 min ☒ 20 min ☒ 25 min ☒
W/CM2: 50 ☒ 1.00 ☒ 1.50 ☒ 2.00 ☒ 2.50 ☒

Manual

To: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒ R UE ☒
L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒ Knee ☒ Ankle ☒
TIME: 15 min ☒ 20 min ☒ 25 min ☒ 30 min ☒
OTHER:

To: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒ R UE ☒
L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒ Knee ☒ Ankle ☒
TIME: 15 min ☒ 20 min ☒ 25 min ☒ 30 min ☒
OTHER:

Anodyne

To: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒ R UE ☒
L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒ Knee ☒ Ankle ☒
TIME: 30 min ☒ 45 min ☒
OTHER:

To: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒ R UE ☒
L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒ Knee ☒ Ankle ☒
TIME: 30 min ☒ 45 min ☒
OTHER:

MH/CP

To: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒
R UE ☒ L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒
Knee ☒ Ankle ☒ TIME: 20 min ☒
OTHER:

To: C/S ☒ Shoulders ☒ Mid Back ☒ Low Back ☒ Hip ☒
R UE ☒ L UE ☒ R LE ☒ L LE ☒ Hand ☒ Elbow ☒ Wrist ☒
Knee ☒ Ankle ☒ TIME: 20 min ☒
OTHER:

Assessment

Rt tal well had no
C/O HA pain to R

Rt tal well had no
C/O HA pain to R

Plan

Cont to correct posture
[Signature]

Cont to correct posture
[Signature]

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

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07/17/2012 13:24 FAX

011

NAME: [REDACTED]

DATE: 3/16/09

SSN: [REDACTED]

DATE: 3/19/09

Subjective

SEE
IEPt. has stated [REDACTED]
had a HA for ~ 2 days
to last 24 hrs NO pain c/o
HA today

Objective

SEE
IENo signif AS-
muscle tensionNEURO
Re-EdTo: C/SO Shoulders Mid Back Low Back Hip R UE
L UE R LEO L LEO Hand Elbow Wrist Knee
Ankle TIME: 10 min 15 min 20 min 25 min
OTHER:To: C/SO Shoulders Mid Back Low Back Hip
L UE R LEO L LEO Hand Elbow Wrist
Ankle TIME: 10 min 15 min 20 min
OTHER:

Massage

To Musculature of: C/SO Shoulders Mid Back Hip
Low Back R UE L UE R LEO L LEO Hand
Wrist Elbow Knee Ankle
TIME: 20 min 25 min 30 min
OTHER:To Musculature of: C/SO Shoulders Mid Back
Low Back R UE L UE R LEO L LEO
Wrist Elbow Knee Ankle HIPS
TIME: 20 min 25 min 30 min
OTHER:

Tape/TE

Kinesio tape: x1 x2 x3
Leuko tape: x1 x2 x3
THERAPEUTIC EXERCISES: 15 min 30 min 45 min
See Flow Sheet 60 minKinesio tape: x1 x2 x3
Leuko tape: x1 x2 x3
THERAPEUTIC EXERCISES: 15 min 30 min 45 min
See Flow Sheet 60 min

Ionio

To: C/SO Shoulders Mid Back Low Back Hip
R UE L UE R LEO L LEO Hand Elbow Wrist Knee
Ankle Dexamethasone Acetic Acid
x1 treatment x2 treatments x24 minutesTo: C/SO Shoulders Mid Back Low Back
R UE L UE R LEO L LEO Hand Elbow Wrist
Ankle Dexamethasone Acetic Acid
x1 treatment x2 treatments x24 minutes

US

To: C/SO Shoulders Mid Back Low Back Hip R UE
L UE R LEO L LEO Hand Elbow Wrist Knee
Ankle TIME: 10 min 15 min 20 min 25 min
W/CM2: .50 1.00 1.50 2.00 2.50To: C/SO Shoulders Mid Back Low Back Hip
L UE R LEO L LEO Hand Elbow Wrist
Ankle TIME: 10 min 15 min 20 min
W/CM2: .50 1.00 1.50 2.00 2.50

Manual

To: C/SO Shoulders Mid Back Low Back Hip R UE
L UE R LEO L LEO Hand Elbow Wrist Knee Ankle
TIME: 15 min 20 min 25 min 30 min
OTHER:To: C/SO Shoulders Mid Back Low Back Hip
L UE R LEO L LEO Hand Elbow Wrist Knee
TIME: 15 min 20 min 25 min 30 min
OTHER:

Anodyne

To: C/SO Shoulders Mid Back Low Back Hip R UE
L UE R LEO L LEO Hand Elbow Wrist Knee Ankle
TIME: 30 min 45 min
OTHER:To: C/SO Shoulders Mid Back Low Back Hip
L UE R LEO L LEO Hand Elbow Wrist Knee
TIME: 30 min 45 min
OTHER:

MH/CF

To: C/SO Shoulders Mid Back Low Back Hip
R UE L UE R LEO L LEO Hand Elbow Wrist
Knee Ankle TIME: 20 min
OTHER:To: C/SO Shoulders Mid Back Low Back
R UE L UE R LEO L LEO Hand Elbow
Knee Ankle TIME: 20 min
OTHER:

Assessment

Pt. still well had
no c/o HA P.R.Pt. still well
had no c/o pain
P.R.

Plan

Cont. to monitor P.R.

Cont. to monitor P.R.

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

Name: _____
Date: 5/03/11 ✓

Date: 5/10/11 ✓

modality sheet

OTHER

AS	FK	
PLAN	Cont'd current doc K. J. Sgroi 1/17	Cont'd current doc K. J. Sgroi 1/17
	Kevin J. Sgroi, RPT	Kevin J. Sgroi, RPT
		modality sheet

07/17/2012 13:12 FAX

0003

Name:

Date:

3/17/11

Date:

4/21/11 ✓

SUBJECTIVE	pt stated the back is feeling better	pt c/o back pain = 4-5/10
OBJECTIVE	no signif 15 min muscle tension	pt has been in N.Y. past two wks
NEURO RE-ED	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ 30 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ 30 MIN □ OTHER:
MASSAGE	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: FA	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: FA
TAPE/TE	KINESIO TAPE: x1 □ x2 □ x3 □ LEUKO TAPE: x1 □ x2 □ x3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET	KINESIO TAPE: x1 □ x2 □ x3 □ LEUKO TAPE: x1 □ x2 □ x3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET
PORTO	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ x1 TREATMENT □ x2 TREATMENTS □ x24 MINUTES □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ x1 TREATMENT □ x2 TREATMENTS □ x24 MINUTES □
US	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □
MANUAL	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:
ANODYNE	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:
NE/C	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:
OTHER	IFC x 20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □	IFC x 20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □
ASSESSMENT	pt to be well had no c/o pain p	pt to be well c/o pain ↓ to = to PR
PLAN	Cont c current for	Cont c current for

Name: [REDACTED]
Date: 2/17/11

Date: 3/3/11

SUBJECTIVE	pt stated she has had tingling in her hands	pt cont to have tingling in feet
OBJECTIVE	No 1's in joint exam	Minor + in muscle tension low back
NEURO RE-ED	TO: C/S L SHOULDERS, MID BACK, LOW BACK, HIP, RUE, LUE, RLE, LLE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN OTHER:	TO: C/S L SHOULDERS, MID BACK, LOW BACK, HIP, RUE, LUE, RLE, LLE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN OTHER:
MASSAGE	TO MUSCULATURE OF: C/S L SHOULDERS, MID BACK, LOW BACK, HIP, RUE, LUE, RLE, LLE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 20 MIN, 25 MIN, 30 MIN, 40 MIN OTHER: FA	TO MUSCULATURE OF: C/S L SHOULDERS, MID BACK, LOW BACK, HIP, RUE, LUE, RLE, LLE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 20 MIN, 25 MIN, 30 MIN, 40 MIN OTHER: FA
TAPE TE	KINESIO TAPE: x1, x2, x3 LEUKO TAPE: x1, x2, x3 THERAPEUTIC EXERCISES: 15 MIN, 30 MIN, 45 MIN, 60 MIN SEE FLOW SHEET	KINESIO TAPE: x1, x2, x3 LEUKO TAPE: x1, x2, x3 THERAPEUTIC EXERCISES: 15 MIN, 30 MIN, 45 MIN, 60 MIN SEE FLOW SHEET
IONTO	TO: C/S L SHOULDERS, MID BACK, LOW BACK, HIP, RUE, LUE, RLE, LLE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT DEXAMETHASONE, ACETIC ACID x1 TREATMENT, x2 TREATMENTS, x24 MINUTES	TO: C/S L SHOULDERS, MID BACK, LOW BACK, HIP, RUE, LUE, RLE, LLE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT DEXAMETHASONE, ACETIC ACID x1 TREATMENT, x2 TREATMENTS, x24 MINUTES
US	TO: C/S L SHOULDERS, MID BACK, LOW BACK, HIP, RUE, LUE, RLE, LLE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN W/CM2: .5, 1.0, 1.5, 2.0, 2.5	TO: C/S L SHOULDERS, MID BACK, LOW BACK, HIP, RUE, LUE, RLE, LLE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN W/CM2: .5, 1.0, 1.5, 2.0, 2.5
MANUAL	TO: C/S L SHOULDERS, MID BACK, LOW BACK, HIP, RUE, LUE, RLE, LLE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN OTHER:	TO: C/S L SHOULDERS, MID BACK, LOW BACK, HIP, RUE, LUE, RLE, LLE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN OTHER:
ANODYNE	TO: C/S L SHOULDERS, MID BACK, LOW BACK, HIP, RUE, LUE, RLE, LLE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 30 MIN, 45 MIN OTHER:	TO: C/S L SHOULDERS, MID BACK, LOW BACK, HIP, RUE, LUE, RLE, LLE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 30 MIN, 45 MIN OTHER:
AGE/CP	TO: C/S L SHOULDERS, MID BACK, LOW BACK, HIP, RUE, LUE, RLE, LLE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 20 MIN, 25 MIN OTHER:	TO: C/S L SHOULDERS, MID BACK, LOW BACK, HIP, RUE, LUE, RLE, LLE, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 20 MIN, 25 MIN OTHER:
OTHER	IFC x 20 MINUTES LASER THERAPEUTIC ACTIVITY OTHER:	IFC x 20 MINUTES LASER THERAPEUTIC ACTIVITY OTHER:
ASSESSMENT	pt got the well had no C10 pain & R	pt got the well had no C10 tingling & R
PLAN	Cont c current PR FA	Cont c current PR FA

Name: [REDACTED]
Date: 2/10/11

Date: 2/10/11

SUBJECTIVE	Pt had no c/o red pain since last tx	Pt had no c/o Ht since last tx
OBJECTIVE	No signif & - gait signature	No T - muscle Tension Low Back
NEURO RE-ED	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ 30 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ 30 MIN □ OTHER:
MASSAGE	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: FA	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: FA
TAPE/TE	KINESIO TAPE: ×1 □ ×2 □ ×3 □ LEUKO TAPE: ×1 □ ×2 □ ×3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET	KINESIO TAPE: ×1 □ ×2 □ ×3 □ LEUKO TAPE: ×1 □ ×2 □ ×3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET
IONTO	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ ×1 TREATMENT □ ×2 TREATMENTS □ ×24 MINUTES □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ ×1 TREATMENT □ ×2 TREATMENTS □ ×24 MINUTES □
US	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □
MANUAL	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:
ANODYNE	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:
MECT	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:
OTHER	IPC × 20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □	IPC × 20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □
	Pt had no c/o pain FB	Pt had no c/o well had no c/o pain FB

Cont & current doc
[Signature]

Cont & current doc
[Signature]

Name:
Date:

1/25/11

Date:

2/1/11

SUBJECTIVE	PT came to Pneumonia C/O r. BP. May be to 7 coughing	PT Mom stated Tingling in r. hand & foot. No C/O r. BP since last
OBJECTIVE	Mod r. muscle Tension Low Back	LBP @ 3/10
NEURO RE-ED	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ 30 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ 30 MIN □ OTHER:
MASSAGE	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER:	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: FA
TAPE/TE	KINESIO TAPE: x1 □ x2 □ x3 □ LEUKO TAPE: x1 □ x2 □ x3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET	KINESIO TAPE: x1 □ x2 □ x3 □ LEUKO TAPE: x1 □ x2 □ x3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET
IONTO	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ x1 TREATMENT □ x2 TREATMENTS □ x24 MINUTES □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ x1 TREATMENT □ x2 TREATMENTS □ x24 MINUTES □
US	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □
MANUAL	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:
ANODYNE	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:
NEUCP	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:
OTHER	IFC x 20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □	IFC x 20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □
ASSESSMENT	PT still has muscle had no C/O pain r. h	PT still has muscle had LBP ↓ to = to r. h
PLAN	Cont & current rx J. H. Grier, PT	Cont & current rx J. H. Grier, PT

Name: *1/11/11*
Date:

Date: *1/18/11*

SUBJECTIVE	<i>Pt c/o Tingling @ ft. Since last tx</i>	<i>Pt still c/o Tingling @ ft. Also c/o a sensation as if H₂O</i>
OBJECTIVE	<i>No t - a tatoo just</i>	<i>is running down the back of her legs</i>
NEURO RE-ED	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:
MASSAGE	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: <i>FA</i>	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: <i>LC</i>
TAPE/TE	KINESIO TAPE: *1 □ *2 □ *3 □ LEUKO TAPE: *1 □ *2 □ *3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET	KINESIO TAPE: *1 □ *2 □ *3 □ LEUKO TAPE: *1 □ *2 □ *3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET
IONTO	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ *1 TREATMENT □ *2 TREATMENTS □ *24 MINUTES □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ *1 TREATMENT □ *2 TREATMENTS □ *24 MINUTES □
US	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □
MANUAL	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:
ANDDYNE	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:
WFCP	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:
OTHER	IPC *20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □	IPC *20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □
ASSESSMENT	<i>Pt still c/o well c/o Tingling @ ft</i>	<i>Pt still c/o well had no c/o pt to R</i>
PLAN	<i>Cont to current doc</i> <i>J. M. Gray</i>	<i>Cont to current doc</i> <i>J. M. Gray</i> 72

07/17/2012 13:15 FAX

008

Name:

Date:

12/14/10

Date:

1/4/10

SUBJECTIVE	Pt had no c/o and pt s/a nice last R	Pt c/o and Ht's over past 2 wk. also c/o Tingling @ ft & legs.
OBJECTIVE	No T-muscle Tension c/s/pain last	Pt stated after playing for a little while @LES become very Tired
NEURO RE-ED	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ LUE □ RLE □ LLE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ LUE □ RLE □ LLE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:
MASSAGE	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ LUE □ RLE □ LLE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: FA	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ LUE □ RLE □ LLE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: FA
TAPETE	KINESIO TAPE: x1 □ x2 □ x3 □ LEUKO TAPE: x1 □ x2 □ x3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET	KINESIO TAPE: x1 □ x2 □ x3 □ LEUKO TAPE: x1 □ x2 □ x3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET
IONTO	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ LUE □ RLE □ LLE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ x1 TREATMENT □ x2 TREATMENTS □ x24 MINUTES □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ LUE □ RLE □ LLE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ x1 TREATMENT □ x2 TREATMENTS □ x24 MINUTES □
US	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ LUE □ RLE □ LLE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ LUE □ RLE □ LLE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □
MANUAL	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ LUE □ RLE □ LLE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ LUE □ RLE □ LLE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:
ANODYNE	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ LUE □ RLE □ LLE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ LUE □ RLE □ LLE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:
MELT	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ LUE □ RLE □ LLE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ RUE □ LUE □ RLE □ LLE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:
OTHER	IFC x20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □	IFC x20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □
ASSESSMENT	Pt sat R well had no c/o pain P R	Pt sat R well minor T-muscle Tension low Back P R
PLAN	Cont to current P R A. J. G. / P R	Cont to current P R A. J. G. / P R

Kevin J. Sarol RPT

Kevin J. Sarol RPT

modelling sheet

Name: [REDACTED]

Date: 11/30/10

Date: 12/19/10

SUBJECTIVE	PT C/O C/S/upper thoracic Pain Pain = 3/10	PT stated she had H/A's since last H No pain upper Thoracic
OBJECTIVE	Mod muscle Tension R @ C/S upper Thoracic	Minor & in muscle Tension To Back
NEURO RE-ED	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:
MASSAGE	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: FA	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: FA
TAPE/TE	KINESIO TAPE: x1 □ x2 □ x3 □ LEUKO TAPE: x1 □ x2 □ x3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET	KINESIO TAPE: x1 □ x2 □ x3 □ LEUKO TAPE: x1 □ x2 □ x3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET
IONTO	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ x1 TREATMENT □ x2 TREATMENTS □ x24 MINUTES □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ x1 TREATMENT □ x2 TREATMENTS □ x24 MINUTES □
US	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □
MANUAL	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:
ANODYNE	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:
MEICP	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UE □ L UE □ R LE □ L LE □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:
OTHER	IFC x 20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □	IFC x 20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □
ASSESSMENT	PT still has well C/O Pain & to = to to to	PT still has well had No C/O H/A's
PLAN	Cont c current doc J. A. Green, PT	Cont c current 74 doc J. A. Green, PT

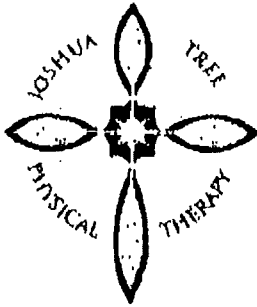
07/17/2012 13:16 FAX

Name:

Date: 10-26-10

Date: 11/9/10

SUBJECTIVE	Pt mother stated her leg felt like jelly	Pt had no c/o fully like feeling in legs
OBJECTIVE	2. Times to the RT	NO antalgic gait
NEURO RE-ED	TO: C/S () SHOULDERS () MID BACK () LOW BACK () HIP () RUE () LUE () RLE () LLE () HAND () WRIST () ELBOW () KNEE () ANKLE () FOOT () TIME: 10 MIN () 15 MIN () 20 MIN () 25 MIN () OTHER:	TO: C/S () SHOULDERS () MID BACK () LOW BACK () HIP () RUE () LUE () RLE () LLE () HAND () WRIST () ELBOW () KNEE () ANKLE () FOOT () TIME: 10 MIN () 15 MIN () 20 MIN () 25 MIN () OTHER:
MASSAGE	TO MUSCULATURE OF: C/S () SHOULDERS () MID BACK () LOW BACK () HIP () RUE () LUE () RLE () LLE () HAND () WRIST () ELBOW () KNEE () ANKLE () FOOT () TIME: 20 MIN () 25 MIN () 30 MIN () 40 MIN () OTHER:	TO MUSCULATURE OF: C/S () SHOULDERS () MID BACK () LOW BACK () HIP () RUE () LUE () RLE () LLE () HAND () WRIST () ELBOW () KNEE () ANKLE () FOOT () TIME: 20 MIN () 25 MIN () 30 MIN () 40 MIN () OTHER:
TAPE/TE	KINESIO TAPE: *1 () *2 () *3 () LEUKO TAPE: *1 () *2 () *3 () THERAPEUTIC EXERCISES: 15 MIN () 30 MIN () 45 MIN () 60 MIN () SEE FLOW SHEET	KINESIO TAPE: *1 () *2 () *3 () LEUKO TAPE: *1 () *2 () *3 () THERAPEUTIC EXERCISES: 15 MIN () 30 MIN () 45 MIN () 60 MIN () SEE FLOW SHEET
IONTO	TO: C/S () SHOULDERS () MID BACK () LOW BACK () HIP () RUE () LUE () RLE () LLE () HAND () WRIST () ELBOW () KNEE () ANKLE () FOOT () DEXAMETHASONE () ACETIC ACID () *1 TREATMENT () *2 TREATMENTS () *24 MINUTES ()	TO: C/S () SHOULDERS () MID BACK () LOW BACK () HIP () RUE () LUE () RLE () LLE () HAND () WRIST () ELBOW () KNEE () ANKLE () FOOT () DEXAMETHASONE () ACETIC ACID () *1 TREATMENT () *2 TREATMENTS () *24 MINUTES ()
US	TO: C/S () SHOULDERS () MID BACK () LOW BACK () HIP () RUE () LUE () RLE () LLE () HAND () WRIST () ELBOW () KNEE () ANKLE () FOOT () TIME: 10 MIN () 15 MIN () 20 MIN () 25 MIN () W/CM2: .5 () 1.0 () 1.5 () 2.0 () 2.5 ()	TO: C/S () SHOULDERS () MID BACK () LOW BACK () HIP () RUE () LUE () RLE () LLE () HAND () WRIST () ELBOW () KNEE () ANKLE () FOOT () TIME: 10 MIN () 15 MIN () 20 MIN () 25 MIN () W/CM2: .5 () 1.0 () 1.5 () 2.0 () 2.5 ()
MANUAL	TO: C/S () SHOULDERS () MID BACK () LOW BACK () HIP () RUE () LUE () RLE () LLE () HAND () WRIST () ELBOW () KNEE () ANKLE () FOOT () TIME: 10 MIN () 15 MIN () 20 MIN () 25 MIN () OTHER:	TO: C/S () SHOULDERS () MID BACK () LOW BACK () HIP () RUE () LUE () RLE () LLE () HAND () WRIST () ELBOW () KNEE () ANKLE () FOOT () TIME: 10 MIN () 15 MIN () 20 MIN () 25 MIN () OTHER:
ANODYNE	TO: C/S () SHOULDERS () MID BACK () LOW BACK () HIP () RUE () LUE () RLE () LLE () HAND () WRIST () ELBOW () KNEE () ANKLE () FOOT () TIME: 30 MIN () 45 MIN () OTHER:	TO: C/S () SHOULDERS () MID BACK () LOW BACK () HIP () RUE () LUE () RLE () LLE () HAND () WRIST () ELBOW () KNEE () ANKLE () FOOT () TIME: 30 MIN () 45 MIN () OTHER:
DE/CP	TO: C/S () SHOULDERS () MID BACK () LOW BACK () HIP () RUE () LUE () RLE () LLE () HAND () WRIST () ELBOW () KNEE () ANKLE () FOOT () TIME: 20 MIN () 25 MIN () OTHER:	TO: C/S () SHOULDERS () MID BACK () LOW BACK () HIP () RUE () LUE () RLE () LLE () HAND () WRIST () ELBOW () KNEE () ANKLE () FOOT () TIME: 20 MIN () 25 MIN () OTHER:
OTHER	(PC *20 MINUTES) LASER () THERAPEUTIC ACTIVITY () OTHER ()	(PC *20 MINUTES) LASER () THERAPEUTIC ACTIVITY () OTHER ()
ASSESSMENT	Pt told her well had no c/o pain to RT	Pt told her well had no c/o pain to RT
PLAN	Cont to carry out RT	Cont to carry out RT



Treatment Note

Joshua Tree Physical Therapy
Hayden
8475 N. Government Way
Suite 102
Hayden, ID 83835
tel: (208) 772-9774
fax: (208) 772-9564

Patient: [REDACTED]
Gender: F
DOB: [REDACTED]

Injury Date: 10/15/2010
Evaluation Date: 03/10/2011
Visit #11: 12/15/2011

Therapist of Record: Kevin J Sgrol PT
Referring Practitioner: Ronda Westcott MD

Provider: Kevin J Sgrol PT
Provider Email: kevin@joshuatreept.com

#	Medical Diagnoses	ICD-9	#	Treating Diagnoses	ICD-9
1)	Lumbago (Back Pain)	724.2	1)	Lumbar segmental dysfunction	739.3
			2)	Lumbar sprain and strain	847.2
			3)	Muscle spasm	728.85
			4)	Musculoskeletal surgical aftercare	V58.78

Patient Status

the patient stated that she had to go to school nurse secondary complaints of headaches and low back pain.

Measures

The following measures were identified for the patient's Lumbar Spine condition:

Measure	Initial (03/10/2011)	Current (12/15/2011)	Target
Standing weight-shift (symptoms) Shifting weight from one leg to the other while standing without symptoms	Severe difficulty; 50 % weight bearing on 1 leg produces symptoms	Severe difficulty; 50 % weight bearing on 1 leg produces symptoms	No difficulty; Bears full weight on 1 leg without symptoms
Sitting (capacity) Ability to sit	Severe difficulty; Only able to sit < 1 hour/day	Severe difficulty; Only able to sit < 1 hour/day	No difficulty; Sitting capability is unlimited
Standing (capacity) Ability to stand	Severe difficulty; Only able to stand < 1 hour/day	Severe difficulty; Only able to stand < 1 hour/day	No difficulty; Standing capability is unlimited
Walking medium distances (symptoms) Walking medium distances without symptoms	Severe problem; Only able to walk < 100 yards without symptoms	Severe problem; Only able to walk < 100 yards without symptoms	No problem; Able to walk > 1000 yards without symptoms
Pain (at rest) Current level of pain	Mild pain; 1/10 to 2/10	Mild pain; 1/10 to 2/10	No pain; 0/10
Pain (at worst) Highest level of pain during the last 24 hours	Severe pain; 8/10 to 9/10	Moderate pain; 3/10 to 5/10	No pain; 0/10
Pain (with movement) Highest level of pain while performing the most aggravating movement	Severe pain; 8/10 to 9/10	Mild pain; 1/10 to 2/10	No pain; 0/10

Measure	Initial (03/10/2011)	Current (12/16/2011)	Target
AROM / Pain (lumbar extension) Movement / pain relations with active lumbar extension	Severe impairment: Pain during initial ranges of active lumbar extension	Moderate impairment: Pain during mid ranges of active lumbar extension	No impairment; No pain with active lumbar extension
AROM / Pain (lumbar flexion) Movement / pain relations with active lumbar flexion	Mild impairment: Pain only at end ranges of active lumbar flexion	Mild impairment: Pain only at end ranges of active lumbar flexion	No impairment; No pain with active lumbar flexion
Flexibility / Muscle length (hip extension / iliacus) Iliacus flexibility	Moderate extension flexibility deficits: -10° to 0°	Moderate extension flexibility deficits: -10° to 0°	Normal extension flexibility; > 10° of hip extension
Flexibility / Muscle length (hamstring / straight leg raise) Hamstring flexibility assessed using the straight leg raising test	Moderate straight leg raise flexibility deficits: 40° to 49°	Moderate straight leg raise flexibility deficits: 40° to 49°	Normal straight leg raise flexibility: > 60°
Strength (lumbar extensors) Lumbar extensors muscle test grade	Moderate weakness: 3/5 strength	Moderate weakness: 3/5 strength	Normal: 5/5 strength
Oswestry Low Back Pain Disability Index (ODI) Score on the Modified Oswestry Low Back Disability Index (ODI)	Severe activity limitation; ODI score 41 to 60	Moderate activity limitation; ODI score 21 to 40	No activity limitation; ODI score 0 to 4

Additional Evaluative Findings

patient had no complaints of numbness/tingling into the bilateral lower extremities.

Treatment Provided Today

The following interventions were performed for the patient's lumbar spine condition:

Massage Therapy (97124):

Cold Laser (97039):

Infrared / Anodyne (97026):

Provider Interactions With Patient During Visit

Verbal and manual cuing on proper performance of the movement.

Assessment

The examination of [REDACTED] identified low back mobility deficits associated with a current post-operative condition. Physical therapy intervention strategies designed to address these impairments will be instrumental in achieving the stated functional goals, including her ability to perform walking tasks. The additional presence of chronic pain in the involved region will likely impact the frequency of physical therapy interventions and will be addressed throughout the episode of care. Based on the examination, the patient's rehabilitation potential to achieve functional goals is excellent.

Functional Goal	Patient Progress
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Low back pain will improve to be able to bend below the waist and lift 10lbs Intermittently for 4 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 60% since initiating therapy. Achieving the patient's goals with continued therapy is expected.
Pelvic girdle pain and strength will improve to be able to weight shift with prolonged standing and walking for 2 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 60 % since initiating therapy. Achieving the patient's goals with continued therapy is expected.

Plan

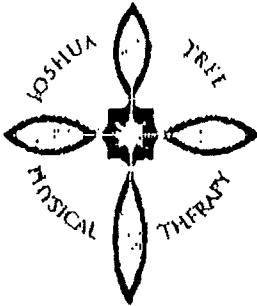
At the next visit, the preferred treatment order is: 1. Modalities, 2. Activities and Exercises, 3. Manual Therapy.

Treatment Time

20 minutes direct contact (lmed) with patient.
50 minutes total treatment time.

Therapist Signature(s)

Electronically signed by Kevin J Sgroi PT on 12/15/2011 11:12:40 PST



Treatment Note

Joshua Tree Physical Therapy
Hayden
8475 N. Government Way
Suite 102
Hayden, ID 83835
tel: (208) 772-9774
fax: (208) 772-9564

Patient: [REDACTED]
Gender: F
DOB: [REDACTED]

Injury Date: 10/15/2010
Evaluation Date: 03/10/2011
Visit #10: 12/06/2011

Therapist of Record: Kevin J Sgroi PT
Referring Practitioner: Ronda Westcott MD

Provider: Kevin J Sgroi PT
Provider Email: kevin@joshuatreept.com

#	Medical Diagnoses	ICD-9	#	Treating Diagnoses	ICD-9
1)	Lumbago (Back Pain)	724.2	1)	Lumbar segmental dysfunction	739.3
			2)	Lumbar sprain and strain	847.2
			3)	Muscle spasm	728.86
			4)	Musculoskeletal surgical aftercare	V58.78

Patient Status

Patient stated that when she bends forward or low back hurts. Patient also complains of headaches on occasion however, unsure frequency.

Measures

The following measures were identified for the patient's Lumbar Spine condition:

Measure	Initial (03/10/2011)	Current (12/06/2011)	Target
Standing weight-shift (symptoms) Shifting weight from one leg to the other while standing without symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	No difficulty: Bears full weight on 1 leg without symptoms
Sitting (capacity) Ability to sit	Severe difficulty: Only able to sit < 1 hour/day	Severe difficulty: Only able to sit < 1 hour/day	No difficulty: Sitting capability is unlimited
Standing (capacity) Ability to stand	Severe difficulty: Only able to stand < 1 hour/day	Severe difficulty: Only able to stand < 1 hour/day	No difficulty: Standing capability is unlimited
Walking medium distances (symptoms) Walking medium distances without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	No problem: Able to walk > 1000 yards without symptoms
Pain (at rest) Current level of pain	Mild pain: 1/10 to 2/10	Mild pain: 1/10 to 2/10	No pain: 0/10
Pain (at worst) Highest level of pain during the last 24 hours	Severe pain: 8/10 to 9/10	Moderate pain: 3/10 to 5/10	No pain: 0/10
Pain (with movement) Highest level of pain while performing the most aggravating movement	Severe pain: 8/10 to 9/10	Mild pain: 1/10 to 2/10	No pain: 0/10

Measure	Initial (03/10/2011)	Current (12/06/2011)	Target
AROM / Pain (lumbar extension) Movement / pain relations with active lumbar extension	Severe impairment: Pain during initial ranges of active lumbar extension	Moderate impairment: Pain during mid ranges of active lumbar extension	No impairment: No pain with active lumbar extension
AROM / Pain (lumbar flexion) Movement / pain relations with active lumbar flexion	Mild impairment: Pain only at end ranges of active lumbar flexion	Mild impairment: Pain only at end ranges of active lumbar flexion	No impairment: No pain with active lumbar flexion
Flexibility / Muscle length (hip extension / iliacus) Iliacus flexibility	Moderate extension flexibility deficits: -10° to 0°	Moderate extension flexibility deficits: -10° to 0°	Normal extension flexibility: > 10° of hip extension
Flexibility / Muscle length (hamstring / straight leg raise) Hamstring flexibility assessed using the straight leg raising test	Moderate straight leg raise flexibility deficits: 40° to 48°	Moderate straight leg raise flexibility deficits: 40° to 48°	Normal straight leg raise flexibility: > 60°
Strength (lumbar extensors) Lumbar extensors muscle test grade	Moderate weakness: 3/5 strength	Moderate weakness: 3/5 strength	Normal: 5/5 strength
Oswestry Low Back Pain Disability Index (ODI) Score on the Modified Oswestry Low Back Disability Index (ODI)	Severe activity limitation: ODI score 41 to 60	Moderate activity limitation: ODI score 21 to 40	No activity limitation: ODI score 0 to 4

Additional Evaluative Findings

patient had no complaints of numbness/tingling into the bilateral lower extremities.

Treatment Provided Today

The following interventions were performed for the patient's lumbar spine condition:

Massage Therapy (97124);

Cold Laser (97039);

Infrared / Anodyne (97020);

Provider Interactions With Patient During Visit

Verbal cuing on proper performance of the movement.

Assessment

The examination of [REDACTED] identified low back mobility deficits associated with a current post-operative condition. Physical therapy intervention strategies designed to address these impairments will be instrumental in achieving the stated functional goals, including her ability to perform walking tasks. The additional presence of chronic pain in the involved region will likely impact the frequency of physical therapy interventions and will be addressed throughout the episode of care. Based on the examination, the patient's rehabilitation potential to achieve functional goals is excellent.

Functional Goal	Patient Progress
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Low back pain will improve to be able to bend below the waist and lift 10lbs intermittently for 4 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 60% since initiating therapy. Achieving the patient's goals with continued therapy is expected.
Pelvic girdle pain and strength will improve to be able to weight shift with prolonged standing and walking for 2 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 50 % since initiating therapy. Achieving the patient's goals with continued therapy is expected.

Plan

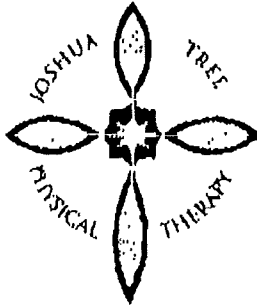
At the next visit, the preferred treatment order is: 1. Modalities, 2. Activities and Exercises, 3. Manual Therapy.

Treatment Time

20 minutes direct contact (timed) with patient.
50 minutes total treatment time.

Therapist Signature(s)

Electronically signed by Kevin J. Egan PT at 12/06/2011 17:12:05 PST



Treatment Note

Joshua Tree Physical Therapy
Hayden
8475 N. Government Way
Suite 102
Hayden, ID 83836
tel: (208) 772-9774
fax: (208) 772-9564

Patient: [REDACTED]
Gender: F
DOB: [REDACTED]

Injury Date: 10/16/2010
Evaluation Date: 03/10/2011
Visit #9: 11/22/2011

Therapist of Record: Kevin J Sgroi PT
Referring Practitioner: Ronda Westcott MD

Provider: Kevin J Sgroi PT
Provider Email: kevin@joshuatreept.com

#	Medical Diagnoses	ICD-9	#	Treating Diagnoses	ICD-9
1)	Lumbago (Back Pain)	724.2	1)	Lumbar segmental dysfunction	739.3
			2)	Lumbar sprain and strain	847.2
			3)	Muscle spasm	728.85
			4)	Musculoskeletal surgical aftercare	V56.78

Patient Status

Patient stated that when she bends forward or low back hurts. Patient also complains of headaches on occasion however, unsure frequency.

Measures

The following measures were identified for the patient's Lumbar Spine condition:

Measure	Initial (03/10/2011)	Current (11/22/2011)	Target
Standing weight-shift (symptoms) Shifting weight from one leg to the other while standing without symptoms	Severe difficulty; 50 % weight bearing on 1 leg produces symptoms	Severe difficulty; 50 % weight bearing on 1 leg produces symptoms	No difficulty; Bears full weight on 1 leg without symptoms
Sitting (capacity) Ability to sit	Severe difficulty; Only able to sit < 1 hour/day	Severe difficulty; Only able to sit < 1 hour/day	No difficulty; Sitting capability is unlimited
Standing (capacity) Ability to stand	Severe difficulty; Only able to stand < 1 hour/day	Severe difficulty; Only able to stand < 1 hour/day	No difficulty; Standing capability is unlimited
Walking medium distances (symptoms) Walking medium distances without symptoms	Severe problem; Only able to walk < 100 yards without symptoms	Severe problem; Only able to walk < 100 yards without symptoms	No problem; Able to walk > 1000 yards without symptoms
Pain (at rest) Current level of pain	Mild pain; 1/10 to 2/10	Mild pain; 1/10 to 2/10	No pain; 0/10
Pain (at worst) Highest level of pain during the last 24 hours	Severe pain; 6/10 to 9/10	Moderate pain; 3/10 to 5/10	No pain; 0/10
Pain (with movement) Highest level of pain while performing the most aggravating movement	Severe pain; 6/10 to 9/10	Mild pain; 1/10 to 2/10	No pain; 0/10

Measure	Initial (03/10/2011)	Current (11/22/2011)	Target
AROM / Pain (lumbar extension) Movement / pain relations with active lumbar extension	Severe impairment; Pain during initial ranges of active lumbar extension	Severe impairment; Pain during initial ranges of active lumbar extension	No impairment; No pain with active lumbar extension
AROM / Pain (lumbar flexion) Movement / pain relations with active lumbar flexion	Mild impairment; Pain only at end ranges of active lumbar flexion	Mild impairment; Pain only at end ranges of active lumbar flexion	No impairment; No pain with active lumbar flexion
Flexibility / Muscle length (hip extension / iliaca) Iliac flexibility	Moderate extension flexibility deficits: -10° to 0°	Moderate extension flexibility deficits: -10° to 0°	Normal extension flexibility: > 10° of hip extension
Flexibility / Muscle length (hamstring / straight leg raise) Hamstring flexibility assessed using the straight leg raising test	Moderate straight leg raise flexibility deficits: 40° to 49°	Moderate straight leg raise flexibility deficits: 40° to 49°	Normal straight leg raise flexibility: > 60°
Strength (lumbar extensors) Lumbar extensors muscle test grade	Moderate weakness; 3/5 strength	Moderate weakness; 3/5 strength	Normal; 5/5 strength
Oswestry Low Back Pain Disability Index (ODI) Score on the Modified Oswestry Low Back Disability Index (ODI)	Severe activity limitation; ODI score 41 to 80	Moderate activity limitation; ODI score 21 to 40	No activity limitation; ODI score 0 to 4

Additional Evaluative Findings

patient had no complaints of numbness/tingling into the bilateral lower extremities.

Treatment Provided Today

The following interventions were performed for the patient's lumbar spine condition:

Massage Therapy (97124):

Cold Laser (97039):

Infrared / Anodyne (97028):

Provider Interactions With Patient During Visit

Verbal cuing on proper performance of the movement.

Verbal cuing on joint protection measures.

Assessment

The examination of [REDACTED] identified low back mobility deficits associated with a current post-operative condition. Physical therapy intervention strategies designed to address these impairments will be instrumental in achieving the stated functional goals, including her ability to perform walking tasks. The additional presence of chronic pain in the involved region will likely impact the frequency of physical therapy interventions and will be addressed throughout the episode of care. Based on the examination, the patient's rehabilitation potential to achieve functional goals is excellent.

Functional Goal	Patient Progress
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Low back pain will improve to be able to bend below the waist and lift 10lbs intermittently for 4 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 50% since initiating therapy. Achieving the patient's goals with continued therapy is expected.
Pelvic girdle pain and strength will improve to be able to weight shift with prolonged standing and walking for 2 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 50 % since initiating therapy. Achieving the patient's goals with continued therapy is expected.

Plan

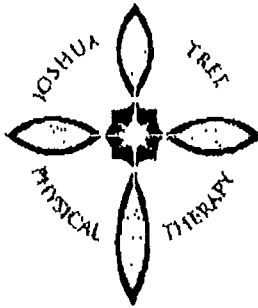
At the next visit, the preferred treatment order is: 1. Modalities, 2. Activities and Exercises, 3. Manual Therapy.

Treatment Time

20 minutes direct contact (timed) with patient.
50 minutes total treatment time.

Therapist Signature(s)

Electronically signed by Kevin J. Spout PT on 11/22/2011 16:11:16 PST



Treatment Note

Joshua Tree Physical Therapy
Hayden
8475 N. Government Way
Suite 102
Hayden, ID 83835
tel: (208) 772-9774
fax: (208) 772-9564

Patient: [REDACTED]
Gender: F
DOB: [REDACTED]

Injury Date: 10/15/2010
Evaluation Date: 03/10/2011
Visit #8: 11/08/2011

Therapist of Record: Kevin J Sgroi PT
Referring Practitioner: Ronda Westcott MD

Provider: Kevin J Sgroi PT
Provider Email: kevin@joshuatreept.com

#	Medical Diagnoses	ICD-9
1)	Lumbago (Back Pain)	724.2

#	Treating Diagnoses	ICD-9
1)	Lumbar segmental dysfunction	739.3
2)	Lumbar sprain and strain	847.2
3)	Muscle spasm	728.85
4)	Musculoskeletal surgical aftercare	V58.78

Patient Status

Patient stated that when she bends forward or low back hurts, Patient also complains of headaches on occasion however, unsure frequency.

Measures

The following measures were identified for the patient's Lumbar Spine condition:

Measure	Initial (03/10/2011)	Current (11/08/2011)	Target
Standing weight-shift (symptoms) Shifting weight from one leg to the other while standing without symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	No difficulty: Bears full weight on 1 leg without symptoms
Sitting (capacity) Ability to sit	Severe difficulty: Only able to sit < 1 hour/day	Severe difficulty: Only able to sit < 1 hour/day	No difficulty: Sitting capability is unlimited
Standing (capacity) Ability to stand	Severe difficulty: Only able to stand < 1 hour/day	Severe difficulty: Only able to stand < 1 hour/day	No difficulty: Standing capability is unlimited
Walking medium distances (symptoms) Walking medium distances without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	No problem: Able to walk > 1000 yards without symptoms
Pain (at rest) Current level of pain	Mild pain: 1/10 to 2/10	Mild pain: 1/10 to 2/10	No pain: 0/10
Pain (at worst) Highest level of pain during the last 24 hours	Severe pain: 8/10 to 9/10	Moderate pain: 3/10 to 5/10	No pain: 0/10
Pain (with movement) Highest level of pain while performing the most aggravating movement	Severe pain: 8/10 to 9/10	Mild pain: 1/10 to 2/10	No pain: 0/10

Measure	Initial (03/10/2011)	Current (11/09/2011)	Target
AROM / Pain (lumbar extension) Movement / pain relations with active lumbar extension	Severe impairment; Pain during initial ranges of active lumbar extension	Severe impairment; Pain during initial ranges of active lumbar extension	No impairment; No pain with active lumbar extension
AROM / Pain (lumbar flexion) Movement / pain relations with active lumbar flexion	Mild impairment; Pain only at end ranges of active lumbar flexion	Mild impairment; Pain only at end ranges of active lumbar flexion	No impairment; No pain with active lumbar flexion
Flexibility / Muscle length (hip extension / Iliacus) Iliacus flexibility	Moderate extension flexibility deficits: -10° to 0°	Moderate extension flexibility deficits: -10° to 0°	Normal extension flexibility; > 10° of hip extension
Flexibility / Muscle length (hamstring / straight leg raise) Hamstring flexibility assessed using the straight leg raising test	Moderate straight leg raise flexibility deficits: 40° to 49°	Moderate straight leg raise flexibility deficits: 40° to 49°	Normal straight leg raise flexibility; > 60°
Strength (lumbar extensors) Lumbar extensors muscle test grade	Moderate weakness; 3/5 strength	Moderate weakness; 3/5 strength	Normal: 5/5 strength
Oswestry Low Back Pain Disability Index (ODI) Score on the Modified Oswestry Low Back Disability Index (ODI)	Severe activity limitation; ODI score 41 to 80	Moderate activity limitation: ODI score 21 to 40	No activity limitation: ODI score 0 to 4

Additional Evaluative Findings

patient had no complaints of numbness/tingling into the bilateral lower extremities.

Treatment Provided Today

The following interventions were performed for the patient's lumbar spine condition:

Massage Therapy (97124);

Cold Laser (97039);

Infrared / Anodyne (97028);

Provider Interactions With Patient During Visit

Verbal cueing on joint protection measures.

Assessment

The examination of [REDACTED] identified low back mobility deficits associated with a current post-operative condition. Physical therapy intervention strategies designed to address these impairments will be instrumental in achieving the stated functional goals, including her ability to perform walking tasks. The additional presence of chronic pain in the involved region will likely impact the frequency of physical therapy interventions and will be addressed throughout the episode of care. Based on the examination, the patient's rehabilitation potential to achieve functional goals is excellent.

Functional Goal	Patient Progress
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07/17/2012 14:17 FAX

013

Low back pain will improve to be able to bend below the waist and lift 10lbs Intermittently for 4 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 50% since initiating therapy. Achieving the patient's goals with continued therapy is expected.
Pelvic girdle pain and strength will improve to be able to weight shift with prolonged standing and walking for 2 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 40 % since initiating therapy. Achieving the patient's goals with continued therapy is expected.

Plan

At the next visit, the preferred treatment order is: 1. Modalities, 2. Activities and Exercises, 3. Manual Therapy.

Treatment Time

20 minutes direct contact (timed) with patient.
50 minutes total treatment time.

Therapist Signature(s)

Electronically signed by Kevin J Sigurdson on 11/08/2011 12:11:14 PST



Treatment Note

Joshua Tree Physical Therapy
Hayden
8476 N. Government Way
Suite 102
Hayden, ID 83835
tel: (208) 772-9774
fax: (208) 772-9564

Patient: [REDACTED]
Gender: F
DOB: [REDACTED]

Injury Date: 10/15/2010
Evaluation Date: 03/10/2011
Visit #7: 11/03/2011

Therapist of Record: Kevin J Sgroi PT
Referring Practitioner: Ronda Westcott MD

Provider: Kevin J Sgroi PT
Provider Email: kevin@joshuatreept.com

#	Medical Diagnoses	ICD-9	#	Treating Diagnoses	ICD-9
1)	Lumbago (Back Pain)	724.2	1)	Lumbar segmental dysfunction	739.3
			2)	Lumbar sprain and strain	847.2
			3)	Muscle spasm	728.85
			4)	Musculoskeletal surgical aftercare	V58.78

Patient Status

Patient stated that when she bends forward or low back hurts. Patient also complains of headaches on occasion however, unsure frequency.

Measures

The following measures were identified for the patient's Lumbar Spine condition:

Measure	Initial (03/10/2011)	Current (11/03/2011)	Target
Standing weight-shift (symptoms) Shifting weight from one leg to the other while standing without symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	No difficulty: Bears full weight on 1 leg without symptoms
Sitting (capacity) Ability to sit	Severe difficulty: Only able to sit < 1 hour/day	Severe difficulty: Only able to sit < 1 hour/day	No difficulty: Sitting capability is unlimited
Standing (capacity) Ability to stand	Severe difficulty: Only able to stand < 1 hour/day	Severe difficulty: Only able to stand < 1 hour/day	No difficulty: Standing capability is unlimited
Walking medium distances (symptoms) Walking medium distances without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	No problem: Able to walk > 1000 yards without symptoms
Pain (at rest) Current level of pain	Mild pain: 1/10 to 2/10	Mild pain: 1/10 to 2/10	No pain: 0/10
Pain (at worst) Highest level of pain during the last 24 hours	Severe pain: 8/10 to 9/10	Moderate pain: 3/10 to 5/10	No pain: 0/10
Pain (with movement) Highest level of pain while performing the most aggravating movement	Severe pain: 8/10 to 9/10	Mild pain: 1/10 to 2/10	No pain: 0/10

07/17/2012 14:35 FAX

003

Measure	Initial (03/10/2011)	Current (11/03/2011)	Target
AROM / Pain (lumbar extension) Movement / pain relations with active lumbar extension	Severe impairment: Pain during initial ranges of active lumbar extension	Severe Impairment: Pain during initial ranges of active lumbar extension	No impairment; No pain with active lumbar extension
AROM / Pain (lumbar flexion) Movement / pain relations with active lumbar flexion	Mild impairment: Pain only at end ranges of active lumbar flexion	Mild Impairment: Pain only at end ranges of active lumbar flexion	No impairment; No pain with active lumbar flexion
Flexibility / Muscle length (hip extension / iliocus) Iliacus flexibility	Moderate extension flexibility deficits: -10° to 0°	Moderate extension flexibility deficits: -10° to 0°	Normal extension flexibility: > 10° of hip extension
Flexibility / Muscle length (hamstring / straight leg raise) Hamstring flexibility assessed using the straight leg raising test	Moderate straight leg raise flexibility deficits: 40° to 49°	Moderate straight leg raise flexibility deficits: 40° to 49°	Normal straight leg raise flexibility: > 60°
Strength (lumbar extensors) Lumbar extensors muscle test grade	Moderate weakness: 3/5 strength	Moderate weakness: 3/5 strength	Normal; 5/5 strength
Oswestry Low Back Pain Disability Index (ODI) Score on the Modified Oswestry Low Back Disability Index (ODI)	Severe activity limitation: ODI score 41 to 80	Moderate activity limitation: ODI score 21 to 40	No activity limitation: ODI score 0 to 4

Additional Evaluative Findings

patient had no complaints of numbness/tingling into the bilateral lower extremities.

Treatment Provided Today

The following interventions were performed for the patient's lumbar spine condition:

Massage Therapy (97124);

Cold Laser (97039);

Infrared / Anodyne (97028);

Provider Interactions With Patient During Visit**Assessment**

The examination of [REDACTED] identified low back mobility deficits associated with a current post-operative condition. Physical therapy intervention strategies designed to address these impairments will be instrumental in achieving the stated functional goals, including her ability to perform walking tasks. The additional presence of chronic pain in the involved region will likely impact the frequency of physical therapy interventions and will be addressed throughout the episode of care. Based on the examination, the patient's rehabilitation potential to achieve functional goals is excellent.

Functional Goal	Patient Progress
Low back pain will improve to be able to bend below the waist and lift 10lbs intermittently for 4 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 40% since initiating therapy. Achieving the patient's goals with continued therapy is expected.

07/17/2012 14:35 FAX

004

Pelvic girdle pain and strength will improve to be able to weight shift with prolonged standing and walking for 2 hours daily for occupational activities; Timeframe: 16 weeks.

The patient reports a reduction in symptoms and improvement in function of more than 40 % since initiating therapy. Achieving the patient's goals with continued therapy is expected.

Plan

At the next visit, the preferred treatment order is: 1. Modalities, 2. Activities and Exercises, 3. Manual Therapy.

Treatment Time

20 minutes direct contact (timed) with patient.
60 minutes total treatment time.

Therapist Signature(s)

Electronically signed by Kevin J. Sigurd PT on 11/03/2011 17:11:08 PT



Treatment Note

Joshua Tree Physical Therapy
Hayden
8475 N. Government Way
Suite 102
Hayden, ID 83835
tel: (208) 772-9774
fax: (208) 772-9564

Patient: [REDACTED]
Gender: F
DOB: [REDACTED]

Injury Date: 10/15/2010
Evaluation Date: 03/10/2011
Visit #6: 10/13/2011

Therapist of Record: Kevin J Sgroi PT
Referring Practitioner: Ronda Westcott MD

Provider: Kevin J Sgroi PT
Provider Email: kevin@joshuatreept.com

#	Medical Diagnoses	ICD-9	#	Treating Diagnoses	ICD-9
1)	Lumbago (Back Pain)	724.2	1)	Lumbar segmental dysfunction	739.3
			2)	Lumbar sprain and strain	847.2
			3)	Muscle spasm	728.85
			4)	Musculoskeletal surgical aftercare	V58.78

Patient Status

Patient complain of increased low back pain when she bends over. She also complained of her legs becoming tired when she plays.

Measures

The following measures were identified for the patient's Lumbar Spine condition:

Measure	Initial (03/10/2011)	Current (10/13/2011)	Target
Standing weight-shift (symptoms) Shifting weight from one leg to the other while standing without symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	No difficulty: Bears full weight on 1 leg without symptoms
Sitting (capacity) Ability to sit	Severe difficulty: Only able to sit < 1 hour/day	Severe difficulty: Only able to sit < 1 hour/day	No difficulty: Sitting capability is unlimited
Standing (capacity) Ability to stand	Severe difficulty: Only able to stand < 1 hour/day	Severe difficulty: Only able to stand < 1 hour/day	No difficulty: Standing capability is unlimited
Walking medium distances (symptoms) Walking medium distances without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	No problem: Able to walk > 1000 yards without symptoms
Pain (at rest) Current level of pain	Mild pain: 1/10 to 2/10	Mild pain: 1/10 to 2/10	No pain: 0/10
Pain (at worst) Highest level of pain during the last 24 hours	Severe pain: 8/10 to 9/10	Moderate pain: 3/10 to 5/10	No pain: 0/10
Pain (with movement) Highest level of pain while performing the most aggravating movement	Severe pain: 8/10 to 9/10	Moderate pain: 3/10 to 5/10	No pain: 0/10

Measure	Initial (03/10/2011)	Current (10/13/2011)	Target
AROM / Pain (lumbar extension) Movement / pain relations with active lumbar extension	Severe impairment; Pain during initial ranges of active lumbar extension	Severe impairment; Pain during initial ranges of active lumbar extension	No impairment; No pain with active lumbar extension
AROM / Pain (lumbar flexion) Movement / pain relations with active lumbar flexion	Mild impairment; Pain only at end ranges of active lumbar flexion	Mild impairment; Pain only at end ranges of active lumbar flexion	No impairment; No pain with active lumbar flexion
Flexibility / Muscle length (hip extension / iliacus) Iliacus flexibility	Moderate extension flexibility deficits: -10° to 0°	Moderate extension flexibility deficits: -10° to 0°	Normal extension flexibility: > 10° of hip extension
Flexibility / Muscle length (hamstring / straight leg raise) Hamstring flexibility assessed using the straight leg raising test	Moderate straight leg raise flexibility deficits: 40° to 49°	Moderate straight leg raise flexibility deficits: 40° to 49°	Normal straight leg raise flexibility: > 60°
Strength (lumbar extensors) Lumbar extensors muscle test grade	Moderate weakness: 3/5 strength	Moderate weakness: 3/5 strength	Normal: 5/5 strength
Oswestry Low Back Pain Disability Index (ODI) Score on the Modified Oswestry Low Back Disability Index (ODI)	Severe activity limitation: ODI score 41 to 80	Moderate activity limitation: ODI score 21 to 40	No activity limitation: ODI score 0 to 4

Additional Evaluative Findings

patient stated that she had no complaints of headaches today.

Treatment Provided Today

The following interventions were performed for the patient's lumbar spine condition:

Massage Therapy (97124);

Cold Laser (97039);

Infrared / Anodyne (97026);

Provider Interactions With Patient During Visit

Verbal cuing on proper performance of the movement.
Verbal cuing on joint protection measures.

Assessment

The examination of [REDACTED] identified low back mobility deficits associated with a current post-operative condition. Physical therapy intervention strategies designed to address these impairments will be instrumental in achieving the stated functional goals, including her ability to perform walking tasks. The additional presence of chronic pain in the involved region will likely impact the frequency of physical therapy interventions and will be addressed throughout the episode of care. Based on the examination, the patient's rehabilitation potential to achieve functional goals is excellent.

Functional Goal	Patient Progress
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07/17/2012 14:36 FAX

007

Low back pain will improve to be able to bend below the waist and lift 10lbs intermittently for 4 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 35% since initiating therapy. Achieving the patient's goals with continued therapy is expected.
Pelvic girdle pain and strength will improve to be able to weight shift with prolonged standing and walking for 2 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 30 % since initiating therapy. Achieving the patient's goals with continued therapy is expected.

Plan

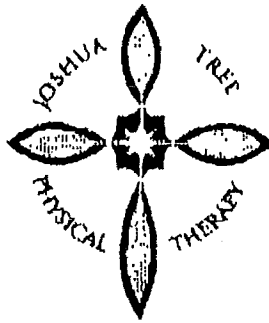
At the next visit, the preferred treatment order is: 1. Modalities, 2. Activities and Exercises, 3. Manual Therapy.

Treatment Time

20 minutes direct contact (timed) with patient.
50 minutes total treatment time.

Therapist Signature(s)

Electronically signed by Kevin J. Syrol PT at 10/13/2011 17:10:57 EDT



Treatment Note

Joshua Tree Physical Therapy
Hayden
8475 N. Government Way
Suite 102
Hayden, ID 83635
tel: (208) 772-9774
fax: (208) 772-9564

Patient: [REDACTED]
Gender: F
DOB: [REDACTED]

Injury Date: 10/15/2010
Evaluation Date: 03/10/2011
Visit #8: 09/29/2011

Therapist of Record: Kevin J Sgrol PT
Referring Practitioner: Ronda Westcott MD

Provider: Kevin J Sgrol PT
Provider Email: kevin@joshuatreept.com

#	Medical Diagnoses	ICD-9	#	Treating Diagnoses	ICD-9
1)	Lumbago (Back Pain)	724.2	1)	Lumbar segmental dysfunction	739.3
			2)	Lumbar sprain and strain	847.2
			3)	Muscle spasm	728.85
			4)	Musculoskeletal surgical aftercare	V68.78

Patient Status

[REDACTED] reports that, overall her condition improved as evidenced by her greater ability to sleep.

Measures

The following measures were identified for the patient's Lumbar Spine condition:

Measure	Initial 03/10/2011	Current: 09/29/2011	Target
Standing weight-shift (symptoms) Shifting weight from one leg to the other while standing without symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	No difficulty: Bears full weight on 1 leg without symptoms
Sitting (capacity) Ability to sit	Severe difficulty: Only able to sit < 1 hour/day	Severe difficulty: Only able to sit < 1 hour/day	No difficulty: Sitting capability is unlimited
Standing (capacity) Ability to stand	Severe difficulty: Only able to stand < 1 hour/day	Severe difficulty: Only able to stand < 1 hour/day	No difficulty: Standing capability is unlimited
Walking medium distances (symptoms) Walking medium distances without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	No problem: Able to walk > 1000 yards without symptoms
Pain (at rest) Current level of pain	Mild pain: 1/10 to 2/10	Mild pain: 1/10 to 2/10	No pain: 0/10
Pain (at worst) Highest level of pain during the last 24 hours	Severe pain: 6/10 to 9/10	Moderate pain: 3/10 to 5/10	No pain: 0/10
Pain (with movement) Highest level of pain while performing the most aggravating movement	Severe pain: 6/10 to 9/10	Severe pain: 6/10 to 9/10	No pain: 0/10

Measure	Initial (08/10/2011)	Current (09/29/2011)	Target
AROM / Pain (lumbar extension) Movement / pain relations with active lumbar extension	Severe impairment: Pain during initial ranges of active lumbar extension	Severe impairment: Pain during initial ranges of active lumbar extension	No impairment: No pain with active lumbar extension
AROM / Pain (lumbar flexion) Movement / pain relations with active lumbar flexion	Mild impairment: Pain only at end ranges of active lumbar flexion	Mild impairment: Pain only at end ranges of active lumbar flexion	No impairment: No pain with active lumbar flexion
Flexibility / Muscle length (hip extension / iliacus) Iliacus flexibility	Moderate extension flexibility deficits: -10° to 0°	Moderate extension flexibility deficits: -10° to 0°	Normal extension flexibility: > 10° of hip extension
Flexibility / Muscle length (hamstring / straight leg raise) Hamstring flexibility assessed using the straight leg raising test	Moderate straight leg raise flexibility deficits: 40° to 49°	Moderate straight leg raise flexibility deficits: 40° to 49°	Normal straight leg raise flexibility: > 60°
Strength (lumbar extensors) Lumbar extensors muscle test grade	Moderate weakness: 3/5 strength	Moderate weakness: 3/5 strength	Normal: 5/5 strength
Oswestry Low Back Pain Disability Index (ODI) Score on the Modified Oswestry Low Back Disability Index (ODI)	Severe activity limitation: ODI score 41 to 80	Moderate activity limitation: ODI score 21 to 40	No activity limitation: ODI score 0 to 4

Additional Evaluative Findings

patient stated that she had no complaints of headaches today.

Treatment Provided Today

The following interventions were performed for the patient's lumbar spine condition:

Massage Therapy (97124):

Cold Laser (97039):

Infrared / Anodyne (97026):

Provider Interactions With Patient During Visit

Verbal cuing on proper performance of the movement.
Verbal cuing on joint protection measures.

Assessment

The examination of [REDACTED] identified low back mobility deficits associated with a current post-operative condition. Physical therapy intervention strategies designed to address these impairments will be instrumental in achieving the stated functional goals, including her ability to perform walking tasks. The additional presence of chronic pain in the involved region will likely impact the frequency of physical therapy interventions and will be addressed throughout the episode of care. Based on the examination, the patient's rehabilitation potential to achieve functional goals is excellent.

Functional Goal	Patient Progress
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Low back pain will improve to be able to bend below the waist and lift 10lbs intermittently for 4 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 35% since initiating therapy. Achieving the patient's goals with continued therapy is expected.
Pelvic girdle pain and strength will improve to be able to weight shift with prolonged standing and walking for 2 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 30 % since initiating therapy. Achieving the patient's goals with continued therapy is expected.

Plan

At the next visit, the preferred treatment order is; 1. Modalities, 2. Activities and Exercises, 3. Manual Therapy.

Treatment Time

20 minutes direct contact (timed) with patient.
50 minutes total treatment time.

Therapist Signature(s)

Electronically signed by Kevin J. Sigel PT on 09/20/2011 17:09:34 PDT



Treatment Note

Joshua Tree Physical Therapy
Hayden
8475 N. Government Way
Suite 102
Hayden, ID 83835
tel: (208) 772-9774
fax: (208) 772-9564

Patient: [REDACTED]
Gender: F
DOB: [REDACTED]

Injury Date: 10/15/2010
Evaluation Date: 03/10/2011
Visit #4: 09/20/2011

Therapist of Record: Kevin J Sgroi PT
Referring Practitioner: Ronda Westcott MD

Provider: Kevin J Sgroi PT
Provider Email: kevin@joshuatreept.com

#	Medical Diagnoses	ICD-9
1)	Lumbago (Back Pain)	724.2

#	Treating Diagnoses	ICD-9
1)	Lumbar segmental dysfunction	739.3
2)	Lumbar sprain and strain	847.2
3)	Muscle spasm	728.85
4)	Musculoskeletal surgical aftercare	V58.78

Patient Status

[REDACTED] reports that, overall her condition improved as evidenced by her greater ability to sleep.

Measures

The following measures were identified for the patient's Lumbar Spine condition:

Measure	Initial (03/10/2011)	Current (09/20/2011)	Target
Standing weight-shift (symptoms) Shifting weight from one leg to the other while standing without symptoms	Severe difficulty; 50 % weight bearing on 1 leg produces symptoms	Severe difficulty; 50 % weight bearing on 1 leg produces symptoms	No difficulty; Bears full weight on 1 leg without symptoms
Sitting (capacity) Ability to sit	Severe difficulty; Only able to sit < 1 hour/day	Severe difficulty; Only able to sit < 1 hour/day	No difficulty; Sitting capability is unlimited
Standing (capacity) Ability to stand	Severe difficulty; Only able to stand < 1 hour/day	Severe difficulty; Only able to stand < 1 hour/day	No difficulty; Standing capability is unlimited
Walking medium distances (symptoms) Walking medium distances without symptoms	Severe problem; Only able to walk < 100 yards without symptoms	Severe problem; Only able to walk < 100 yards without symptoms	No problem; Able to walk > 1000 yards without symptoms
Pain (at rest) Current level of pain	Mild pain; 1/10 to 2/10	Mild pain; 1/10 to 2/10	No pain; 0/10
Pain (at worst) Highest level of pain during the last 24 hours	Severe pain; 6/10 to 9/10	Moderate pain; 3/10 to 5/10	No pain; 0/10
Pain (with movement) Highest level of pain while performing the most aggravating movement	Severe pain; 6/10 to 9/10	Severe pain; 6/10 to 9/10	No pain; 0/10

Measure	Initial (03/10/2011)	Current (09/20/2011)	Target
AROM / Pain (lumbar extension) Movement / pain relations with active lumbar extension	Severe impairment; Pain during initial ranges of active lumbar extension	Severe impairment; Pain during initial ranges of active lumbar extension	No impairment; No pain with active lumbar extension
AROM / Pain (lumbar flexion) Movement / pain relations with active lumbar flexion	Mild impairment; Pain only at end ranges of active lumbar flexion	Mild impairment; Pain only at end ranges of active lumbar flexion	No impairment; No pain with active lumbar flexion
Flexibility / Muscle length (hip extension / iliacus) Iliacus flexibility	Moderate extension flexibility deficits: -10° to 0°	Moderate extension flexibility deficits: -10° to 0°	Normal extension flexibility: > 10° of hip extension
Flexibility / Muscle length (hamstring / straight leg raise) Hamstring flexibility assessed using the straight leg raising test	Moderate straight leg raise flexibility deficits: 40° to 49°	Moderate straight leg raise flexibility deficits: 40° to 49°	Normal straight leg raise flexibility: > 60°
Strength (lumbar extensors) Lumbar extensors muscle test grade	Moderate weakness: 3/5 strength	Moderate weakness: 3/5 strength	Normal: 5/5 strength
Oswestry Low Back Pain Disability Index (ODI) Score on the Modified Oswestry Low Back Disability Index (ODI)	Severe activity limitation: ODI score 41 to 80	Moderate activity limitation: ODI score 21 to 40	No activity limitation: ODI score 0 to 4

Additional Evaluative Findings

Patient complained of increased cervical spine pain and headaches since last treatment.

Treatment Provided Today

The following interventions were performed for the patient's lumbar spine condition:

Massage Therapy (97124):

Cold Laser (97039):

Infrared / Anodyne (97028):

Provider Interactions With Patient During Visit

Verbal cueing on proper performance of the movement.

Assessment

The examination of [REDACTED] identified low back mobility deficits associated with a current post-operative condition. Physical therapy intervention strategies designed to address these impairments will be instrumental in achieving the stated functional goals, including her ability to perform walking tasks. The additional presence of chronic pain in the involved region will likely impact the frequency of physical therapy interventions and will be addressed throughout the episode of care. Based on the examination, the patient's rehabilitation potential to achieve functional goals is excellent.

Functional Goal	Patient Progress
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07/17/2012 14:44 FAX

007

Low back pain will improve to be able to bend below the waist and lift 10lbs Intermittently for 4 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 35% since initiating therapy. Achieving the patient's goals with continued therapy is expected.
Pelvic girdle pain and strength will improve to be able to weight shift with prolonged standing and walking for 2 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 30 % since initiating therapy. Achieving the patient's goals with continued therapy is expected.

Plan

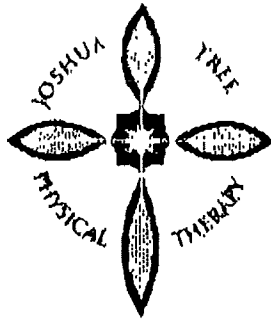
At the next visit, the preferred treatment order is: 1. Modalities, 2. Activities and Exercises, 3. Manual Therapy.

Treatment Time

20 minutes direct contact (timed) with patient,
60 minutes total treatment time.

Therapist Signature(s)

Electronically signed by Kevin J. Spina PT on 09/20/2011 17:09:41 PDT



Treatment Note

Joshua Tree Physical Therapy
Hayden
8475 N. Government Way
Suite 102
Hayden, ID 83835
tel: (208) 772-9774
fax: (208) 772-9564

Patient: [REDACTED]
Gender: F
DOB: [REDACTED]

Injury Date: 10/15/2010
Evaluation Date: 03/10/2011
Visit #3: 08/29/2011

Therapist of Record: Kevin J Sgroi PT
Referring Practitioner: Ronde Westcott MD

Provider: Kevin J Sgroi PT
Provider Email: kevin@joshuatreetpt.com

#	Medical Diagnoses	ICD-9	#	Treating Diagnoses	ICD-9
1)	Lumbago (Back Pain)	724.2	1)	Lumbar segmental dysfunction	739.3
			2)	Lumbar sprain and strain	847.2
			3)	Muscle spasm	728.85
			4)	Musculoskeletal surgical aftercare	V58.70

Patient Status

[REDACTED] reports that, overall her condition improved as evidenced by her greater ability to sleep.

Measures

The following measures were identified for the patient's Lumbar Spine condition:

Measure	Initial (02/10/2011)	Current (08/29/2011)	Target
Standing weight-shift (symptoms) Shifting weight from one leg to the other while standing without symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	No difficulty: Bears full weight on 1 leg without symptoms
Sitting (capacity) Ability to sit	Severe difficulty: Only able to sit < 1 hour/day	Severe difficulty: Only able to sit < 1 hour/day	No difficulty: Sitting capability is unlimited
Standing (capacity) Ability to stand	Severe difficulty: Only able to stand < 1 hour/day	Severe difficulty: Only able to stand < 1 hour/day	No difficulty: Standing capability is unlimited
Walking medium distances (symptoms) Walking medium distances without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	No problem: Able to walk > 1000 yards without symptoms
Pain (at rest) Current level of pain	Mild pain: 1/10 to 2/10	Mild pain: 1/10 to 2/10	No pain: 0/10
Pain (at worst) Highest level of pain during the last 24 hours	Severe pain: 6/10 to 9/10	Severe pain: 6/10 to 9/10	No pain: 0/10
Pain (with movement) Highest level of pain while performing the most aggravating movement	Severe pain: 6/10 to 9/10	Severe pain: 6/10 to 9/10	No pain: 0/10

Measure	Initial (08/10/2011)	Current (05/29/2015)	Target
AROM / Pain (lumbar extension) Movement / pain relations with active lumbar extension	Severe Impairment: Pain during initial ranges of active lumbar extension	Severe Impairment: Pain during initial ranges of active lumbar extension	No Impairment: No pain with active lumbar extension
AROM / Pain (lumbar flexion) Movement / pain relations with active lumbar flexion	Mild impairment: Pain only at end ranges of active lumbar flexion	Mild Impairment: Pain only at end ranges of active lumbar flexion	No Impairment: No pain with active lumbar flexion
Flexibility / Muscle length (hip extension / Iliacus) Iliacus flexibility	Moderate extension flexibility deficits: -10° to 0°	Moderate extension flexibility deficits: -10° to 0°	Normal extension flexibility: > 10° of hip extension
Flexibility / Muscle length (hamstring / straight leg raise) Hamstring flexibility assessed using the straight leg raising test	Moderate straight leg raise flexibility deficits: 40° to 49°	Moderate straight leg raise flexibility deficits: 40° to 49°	Normal straight leg raise flexibility: > 60°
Strength (lumbar extensors) Lumbar extensors muscle test grade	Moderate weakness: 3/5 strength	Moderate weakness: 3/5 strength	Normal: 5/5 strength
Oswestry Low Back Pain Disability Index (ODI) Score on the Modified Oswestry Low Back Disability Index (ODI)	Severe activity limitation: ODI score 41 to 60	Moderate activity limitation: ODI score 21 to 40	No activity limitation: ODI score 0 to 4

Additional Evaluative Findings

patient has moderate to severe tonic muscle spasms throughout the cervical spine and lumbar.

Treatment Provided Today

The following interventions were performed for the patient's lumbar spine condition:

Massage Therapy (97124):

Cold Laser (97039):

Infrared / Anodyne (97028):

Provider Interactions With Patient During Visit

Verbal cueing on proper performance of the movement.

Assessment

The examination of [REDACTED] identified low back mobility deficits associated with a current post-operative condition. Physical therapy intervention strategies designed to address these impairments will be instrumental in achieving the stated functional goals, including her ability to perform walking tasks. The additional presence of chronic pain in the involved region will likely impact the frequency of physical therapy interventions and will be addressed throughout the episode of care. Based on the examination, the patient's rehabilitation potential to achieve functional goals is excellent.

Functional Goal	Patient Progress
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Low back pain will improve to be able to bend below the waist and lift 10lbs Intermittently for 4 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 25 % since initiating therapy. Achieving the patient's goals with continued therapy is expected.
Pelvic girdle pain and strength will improve to be able to weight shift with prolonged standing and walking for 2 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 25 % since initiating therapy. Achieving the patient's goals with continued therapy is expected.

Plan

At the next visit, the preferred treatment order is: 1. Modalities, 2. Activities and Exercises, 3. Manual Therapy.

Treatment Time

20 minutes direct contact (timed) with patient.
 60 minutes total treatment time.

Therapist Signature(s)

Electronically signed by Kevin J Sgroi PT on 08/29/2011 13:08:56 PM



Initial Evaluation

Joshua Tree Physical Therapy
Hayden
8475 N. Government Way
Suite 102
Hayden, ID 83835
tel: (208) 772-9774
fax: (208) 772-9564

Patient: [REDACTED]
Gender: F
DOB: [REDACTED]

Injury Date: 10/15/2010
Evaluation Date: 03/10/2011
Visit #1: 03/10/2011

Therapist of Record:
Referring Practitioner: Ronda Westcott MD

Provider: Kevin J Sgroi PT
Provider Email: kevin@joshuatreept.com

#	Medical Diagnoses	ICD-9	#	Treating Diagnoses	ICD-9
1)	Lumbago (Back Pain)	724.2	1)	Lumbar segmental dysfunction	739.3
			2)	Lumbar sprain and strain	847.2
			3)	Muscle spasm	728.85
			4)	Musculoskeletal surgical aftercare	V58.78

Reason For Referral

[REDACTED] is a [REDACTED] year-old female, who reports a history of gradually increasing low back pain, that began approximately in June of 2008 and was associated with surgical intervention for spinal cord abnormality: Arnold Chiari disease. She has now been referred to physical therapy to begin postoperative rehabilitation. Ms. Bryant is an otherwise healthy female without any prior medical complications that would limit her full and active participation in rehabilitation.

Medical History

Fall History: Patient has not been injured by a fall in the past year. Patient has not had two or more falls in the past year.

Clinical Findings

- Lumbar Spine:**
 - Pain location - low back, buttock or posterior thigh (unilateral): yes
 - Pain location - low back, thigh, calf, ankle or foot: yes
 - Paresthesia location - lower limb: yes
 - Radiating pain location - shooting, narrow band of pain into the leg: yes
 - Aggravating factors - end-range sidebending motions: yes
 - Aggravating factors - prolonged lumbar extension: yes
 - Leg length discrepancy: yes
 - Active movement tests (low back): restricted extension, restricted left side bending, restricted right side bending, pain limits extension
 - Repeated movement tests (low back): lumbar extension peripheralizes symptoms
 - Palpation - psoas major (provocation reproduces symptoms): positive
 - Palpation - quadratus lumborum (provocation reproduces symptoms): positive
 - Radiolar symptoms: numbness, tingling, pain

Measures

The following measures were identified for the patient's Lumbar Spine condition:

Measure	Current (03/10/2011)	Target
Standing weight-shift (symptoms) Shifting weight from one leg to the other while standing without symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	No difficulty: Bears full weight on 1 leg without symptoms
Sitting (capacity) Ability to sit	Severe difficulty: Only able to sit < 1 hour/day	No difficulty: Sitting capability is unlimited
Standing (capacity) Ability to stand	Severe difficulty: Only able to stand < 1 hour/day	No difficulty: Standing capability is unlimited
Walking medium distances (symptoms) Walking medium distances without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	No problem: Able to walk > 1000 yards without symptoms
Pain (at rest) Current level of pain	Mild pain: 1/10 to 2/10	No pain: 0/10
Pain (at worst) Highest level of pain during the last 24 hours	Severe pain: 6/10 to 9/10	No pain: 0/10
Pain (with movement) Highest level of pain while performing the most aggravating movement	Severe pain: 6/10 to 9/10	No pain: 0/10
AROM / Pain (lumbar extension) Movement / pain relations with active lumbar extension	Severe impairment: Pain during initial ranges of active lumbar extension	No impairment: No pain with active lumbar extension
AROM / Pain (lumbar flexion) Movement / pain relations with active lumbar flexion	Mild impairment: Pain only at end ranges of active lumbar flexion	No impairment: No pain with active lumbar flexion
Flexibility / Muscle length (hip extension / iliopsoas) Iliopsoas flexibility	Moderate extension flexibility deficits: -10° to 0°	Normal extension flexibility: > 10° of hip extension
Flexibility / Muscle length (hamstring / straight leg raise) Hamstring flexibility assessed using the straight leg raising test	Moderate straight leg raise flexibility deficits: 40° to 49°	Normal straight leg raise flexibility: > 60°
Strength (lumbar extensors) Lumbar extensors muscle test grade	Moderate weakness: 3/5 strength	Normal: 5/5 strength
Oswestry Low Back Pain Disability Index (ODI) Score on the Modified Oswestry Low Back Disability Index (ODI)	Severe activity limitation: ODI score 41 to 80	No activity limitation: ODI score 0 to 4

Additional Evaluative Findings

Patient also complains of periodic symptoms throughout the bilateral upper extremities were with radiculopathy.

Assessment

The examination of [REDACTED] identified low back mobility deficits associated with a current post-operative condition. Physical therapy intervention strategies designed to address these impairments will be instrumental in achieving the stated functional goals, including her ability to perform walking tasks. The additional presence of chronic pain in the involved region will likely impact the frequency of physical therapy interventions and will be addressed throughout the episode of care. Based on the examination, the patient's rehabilitation potential to achieve functional goals is excellent.

Plan of Care: Lumbar spine

Functional Goals:

1. Low back pain will improve to be able to bend below the waist and lift 10lbs intermittently for 4 hours daily for occupational activities; Timeframe: 16 weeks.

2.

Pelvic girdle pain and strength will improve to be able to weight shift with prolonged standing and walking for 2 hours daily for occupational activities; Timeframe: 16 weeks.

Intervention Strategy

Lumbar Spine

Neuromuscular Reeducation techniques incorporating verbal, manual and proprioceptive performance cues to reeducate movement patterns, improve coordination, normalize lumbopelvic posture and integrate the endurance, motor control and flexibility gains with the ability perform sustained functional movements and activities with reduced or eliminated symptoms.

Massage Therapy to improve tissue fluid and soft tissue mobility required for optimal, pain free functioning.

Cold Laser to reduce pain and inflammation in the involved region.

Hot/Cold Pack to reduce pain, improve circulation and enable the involved tissues to maximally benefit from this visit's therapeutic procedures.

Infrared / Anodyne to reduce pain in the involved region.

Recommendations

██████████ will be seen for physical therapy as described at the following frequency and duration: 2 visits per week for 16 weeks.

Treatment Provided Today

The following interventions were performed for the patient's lumbar spine condition:

Initial Evaluation PT (97001):

Therapeutic Exercise (97110):

Neuromuscular Reeducation (97112):

Massage Therapy (97124):

Self-care / Home Management Training (97535):

Cold Laser (97030):

Infrared / Anodyne (97026):

Education materials were given to patient for the following home exercises

Hip Internal Rotation Stretching 1

Provider Interactions With Patient During Visit

Verbal cuing on proper performance of the movement.

Verbal and manual cuing to facilitate efficient motor performance of the movement.

Verbal cuing on joint protection measures.

Treatment Time

35 minutes direct contact (timed) with patient.

110 minutes total treatment time.

Therapist Signature(s)

Electronically signed by Kevin J Segol PT at 08/24/2011 10:08:33 PDT

Referral Signature

☐ I certify and concur with the outlined Plan of Care and that this patient remains under my care.

☐

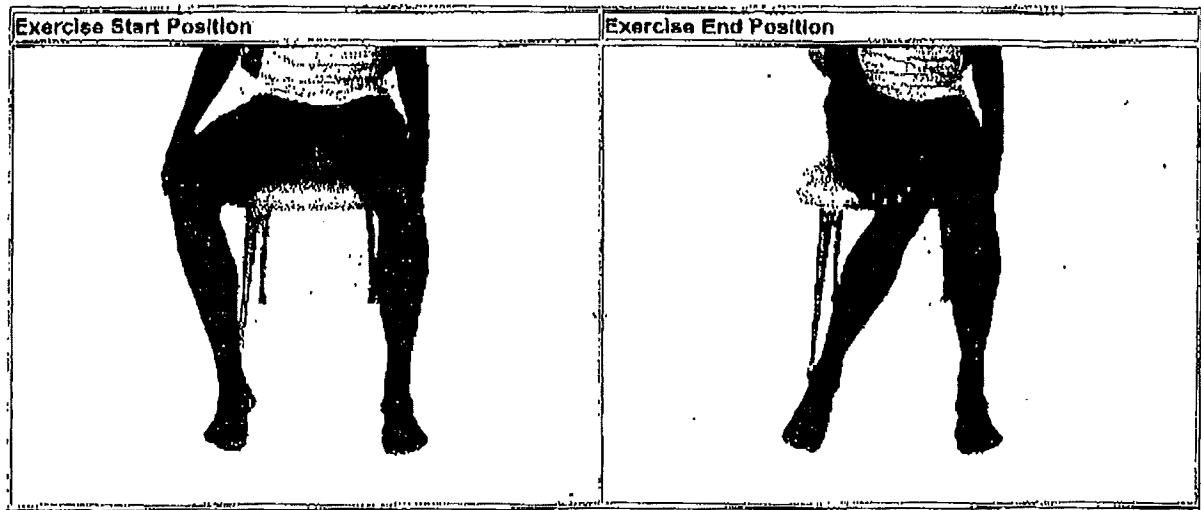
Referral Signature: _____

Date: _____

Print Name: _____

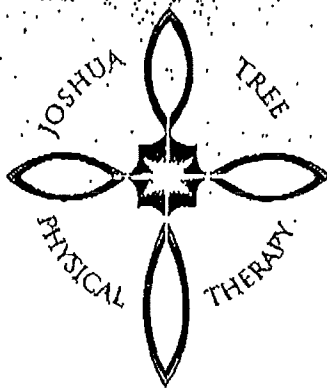
Ronda Westcott MD

Hip Internal Rotation Stretching, Level 1



Performance Cues

- Sit at the edge of a stable chair, feet wider than shoulders-width
- Allow one knee to drop in towards the other without twisting the body
- To provide more of a stretch, apply moderate pressure to the outside of the knee that is dropped inwards



JOSHUA TREE PHYSICAL THERAPY

Initial Evaluation

Date: October 15, 2010.

Physician: Dr. Westcott

Re: [REDACTED]

Diagnosis: Mid/ Low back pain.

Dear Dr. Westcott:

Thank you for referring your patient to Joshua Tree Physical Therapy. Upon initial evaluation the following was determined.

History: The patient is a [REDACTED] female with complaints of mid and low back pain. At rest pain is rated at approximately 2/10 to 3/10 and increases to approximately 5/10 to 6/10 with activities of daily living. Patient does complain of radiating pain into the bilateral lower lower extremities. However, the patient does not complain of numbness and tingling into the bilateral lower extremities. Patient does complain of occasional headaches these are rated as moderate to severe.

PMH: Patient has been diagnosed with Chiari. Patient has undergone several surgical procedures secondary to this diagnosis. There has been a duraplasty patch surgically implanted at the base of the child's skull. She also has a lumbar shunt to enhance the flow of cerebral spinal fluid. Patient also had surgery for removal of vertebrae C1 and L3 through L5. Patient also has been diagnosed with hypercalcemic production and is taking medication HCTC for this condition.

Objective:

Active Range of Motion

Loss of Movement:

Lumbar flexion:	Moderate with severe complaints of low back pain
Lumbar extension:	Minimal with complaints of low back pain.
Lateral flexion left:	Minimal with complaints of tightness and pulling
Lateral flexion right:	Minimal with complaints of tightness and pulling
Rotation right:	None without complaints of pain
Rotation left:	None without complaints of pain

Manual Muscle Test:

	Left	Right.
Quadriceps:	4/5	4+/5
Hamstrings:	4/5	4+/5
Ankle plantarflexion:	4/5	4+/5
Dorsiflexion:	4/5	4+/5
Dorsi flexion great toe:	4/5	4+/5

Objective:

AROM.

	Left		Right.
Cervical flexion:		80 % of normal	
Cervical extension:		90 % of normal,	
Lateral flexion:	80 %		80%,
Rotation:	90 %		90%,
Shoulder AROM:	180°		180°

8475 NORTH GOVERNMENT WAY, HAYDEN, IDAHO 83815

PHONE: 208-772-9774 FAX: 208-772-9564

(flexion)

Observation: Patient is able to perform bilateral heel raises equally however, when performing heel raises unilaterally the patient had more difficulty raising the heel on right when compared to left.

Reflexes: Left Achilles and patella reflexes are within normal limits. Right Achilles and patella reflexes are moderately diminished.

Palpation: There are noted numerous trigger points and tonic muscle spasms throughout the cervical, thoracic, and lumbar paraspinals.

Treatment Program: The patient will receive education on proper body mechanics and posture. Treatment and modalities will include, anodyne light treatment, medical massage, neuromuscular reeducation, therapeutic laser, therapeutic exercises, and home exercise program.

Assessment:

Problem List:

- Complaints of pain at rest.
- Complaints of pain with activities of daily living.
- Tonic muscle spasms noted throughout all paraspinals.
- Decreased active range of motion cervical spine and lumbar spine.
- Complaints of constant headaches

Short-Term Goals: Four weeks

- Decrease complaints of pain at rest by 50%.
- Decrease tonic muscle spasms by 50%.
- Increase active range of motion cervical and lumbar spine to WNL.

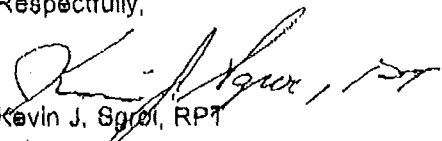
Long-term goals: Eight weeks.

- Decrease complaints of pain at rest to 0/10.
- Patient to perform activities daily living without complaints of pain.
- Decrease tonic muscle spasms by 90%.
- Patient to be independent with supervision in home exercise program.

Plan of Care: The patient will receive the above treatment program two to three times a week for up to eight weeks. The treatment program will be upgraded and modified as per physician's recommendations and as patient tolerates to achieve the above goals.

Once, again thank you for referring your patient to Joshua Tree Physical Therapy. If you have any questions or recommendations about your patient's care please contact me at your earliest convenience.

Respectfully,


Kevin J. Sgroi, RPT